

ADVOCACY AND PARTICIPATION IN MENTAL HEALTH CASES: REALISABLE RIGHTS OR PIPE-DREAMS?

TERRY CARNEY, FLEUR BEAUPERT, JULIA PERRY AND DAVID TAIT.¹

States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages (*Convention on the Rights of Persons with Disabilities 2006*, Art 13(1)).

The role of lawyers and other legal actors in the mental health process needs to be re-conceptualized to accommodate the reality that the law's intent is therapeutic, that therapy 'works' in the large majority of cases (typically in short order), and that the vast majority of those proposed for treatment are in need of treatment, their inability to recognize this notwithstanding. To make a police operation out of the state's efforts to provide needed care and treatment is misguided, as is the adversarial inclination to exploit the already excessive [USA] criminal-law style protections that surround the process in an effort to keep as many people from obtaining treatment as possible (Brakel, 2007: 498-499).

A. INTRODUCTION

Access to a lawyer is a fundamental right for a person faced with a legal process in which their liberty is at risk (*Gideon v Wainwright* (372 US 335-345 (1963))). Nowhere is this risk more evident than in mental health tribunal review hearings about detaining a person against their will, often when family or friends have initiated committal (Brakel, 2007: 488).

¹ Terry Carney, Professor of Law, the University of Sydney; Fleur Beaupert, doctoral candidate, University of Sydney; Julia Perry, Senior Research Assistant, University of Sydney; David Tait, Associate Professor, School of Law, University of Canberra. This research is funded by an ARC Linkage collaborative grant, studying the Victorian, NSW and the ACT Tribunals, supported by the Law and Justice Foundation of NSW. Ms Alikki Vernon made valuable comments on this paper.

Article 13(1) of the *Convention on the Rights of Persons with Disabilities* 2006 ('UN Disability Rights Convention') makes it clear that persons with disabilities should have 'effective access to justice ... on an equal basis with others'. Article 17 requires governments to respect the 'physical and moral integrity' of all persons. The United Nations *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* (1991) ('MI Principles') include: a patient's right to choose and appoint a legal representative (Principle 18), access to legal aid for the indigent (Principle 1(6)) and a personal representative apart from a family member (Principle 2) (further, Zuckerberg, 2007: 521). Mandatory, free, and high quality legal representation for people facing mandatory detention for a mental illness, is similarly supported by the World Health Organisation (WHO, 2003).

Yet Jan Brakel claims that the protection of a lawyer in a mental health review process may be 'excessive', that it is based on a false analogy with criminal law, and that the 'adversarial inclination' represented by lawyers may actually interfere with promoting therapeutic outcomes. Brakel's scepticism cannot lightly be dismissed, given his primary role in the ABA's landmark report *The Mentally Disabled and the Law* (1961, rev 1971, 3rd ed 1985).

So is there a role for advocacy in mental health review processes, and if so what should this be? Is there a 'basic dishonesty' associated with tolerating superficial or 'peripheral' review processes which fail to properly engage the clinical evidence, as Bruce Winick (2005: 145) suggests? Or is Michael Perlin on the right track in recommending a fully *effective* quality of representation in place of the minimum 'industry standard' currently offered by lawyers (Perlin, 2008)? And why is legal representation for indigent mental health clients provided in only half of US jurisdictions (Abel and Rettig, 2006: 264-268)? At a period when the UN Disability Rights Convention is being signed, a UN Committee established to monitor compliance (UN, 2007), and rights 'proliferating' (Gable, 2007), it is timely to re-examine the best way to protect the rights of people with a mental illness.

This article discusses Australian experiences of mental health clients, legal advocates and other stakeholders in the mental health review system. We review forms of advocacy, the reactions to these, and the contribution lawyers make to protecting rights within this field. Based on our fieldwork we suggest a mixed model of advocacy, one that includes legal representation that goes beyond simple 'following instructions', but also self-advocacy, systemic advocacy and mobilisation of support networks. We suggest that Brakel is right to call for a re-conceptualisation of advocacy, and indicate ways this might be achieved.

B. ADVOCACY AND PARTICIPATION RIGHTS IN AUSTRALIAN MENTAL HEALTH TRIBUNALS

1. Availability and 'styles' of mental health advocacy in Australia

Legal representation for patients facing involuntary hospitalisation was not the norm historically in Australia, and it remains patchy. New Zealand reports representation rates of 69 per cent (O'Brien, Mellsop, McDonald and Ruthe, 1995), though it was said to delay hearings without significantly boosting chances of discharge.

Representation at Australian MHT hearings is still comparatively rare (5-10% in Victoria), partly because legal aid concentrates on involuntary in-patient admissions, neglecting the vast bulk of people on Community Treatment Orders (CTOs). In Swain's 2000 Victorian study, advocates appeared in just 8 per cent of cases, a rate which has remained stable (Swain, 2000; MHRB, 2006: 31; Lesser, 2007: 12). Similar rates (8.3%) apply in WA (MHRB(WA), 2006). Representation was higher in NSW in 2006 (16.2%), but mostly for inpatient rather than CTO reviews (MHRT(NSW), 2006).

This low rate of legal representation is not for lack of evidence about need.

a. Origins of legal representation before Australian MHTs

Robert Wheeler (2001: 1) notes that legal representation at NSW Magistrates' reviews of involuntary admissions began in the 1970s, following 1966 research that half of Rozelle hospital's involuntary patients did not meet legal definitions of mental illness, and 1977 Rozelle findings that 98 percent of all six month orders entailed just a five minute 'hearing' (with doctors attending only one in 20 cases). Piloting of legal representation in 1982-83 drastically reduced average durations of committal orders (from 6 to 1-3 months), boosting median hearing duration from the former 3-4 minutes to a still short 10-15 minutes—as had occurred overseas (Wenger and Fletcher, 1969). The NSW Mental Health Advocacy Service started in 1986, and four years later the then *Mental Health Act 1990* (NSW) made representation mandatory at Magistrate's inquiries unless specifically declined by patients (Wheeler, *ibid*; now NSW MHA 2007 Sch 2, cl 1(6)).

The extent of coverage and the degree of expertise of legal representation is largely an artefact of the rationing principles adopted by the relevant legal aid agencies, and the degree of specialisation of delivery of legal services.

b. Current patterns of legal representation before MHTs

In Victoria legal aid is available to a person in hospital (an issue of perceived liberty), although the Legal Aid Commission assesses cases before offering representation. Cases represented include first admissions, children, mothers and those whose cases have merit.

So if someone say is quite well ... we will assess their matter. It doesn't necessarily mean that we will provide representation. We usually represent people who do require it. So it's normal that we provide that representation. We try always to provide representation to first admissions, no matter what their age is. ... We always try and represent children, because it's a quite frightening system, and it's usually their first attendance (Interview with Victorian Legal Aid Commission, March 2008).

However, legal aid representation is not offered to inpatients appearing to be seriously mentally ill:

If someone is completely psychotic and there's going to be no benefit, we would not represent them. So if they were really, really, really quite ill, and there was obviously not benefit in the representation, they'd been in hospital many, many, many times before, and they were quite ill, we would not provide them with representation (Interview with Victorian Legal Aid Commission).

Under this rationing, legal representation is made available either where the person is particularly vulnerable or where the person has a realistic prospect of being discharged from an order. In the first case, the advocate might be expected to play a supportive or informational role, in the latter the advocate is more likely to pursue legal avenues for securing release of their client. A separate service, the Mental Health Legal Centre ('MH Legal Centre') provides individual advocacy for outpatients, including CTO reviews.

Allocation of legal aid is confined primarily to inpatient hearings in NSW (now covering *all* inpatient admissions) and the ACT, where a duty lawyer is available to hospitalised patients (LAC(ACT), 2008). The NSW Mental Health Advocacy Service (MHAS, 2008) recently extended its policy to provide some grants of aid for CTO cases and created a position of consumer advocate to undertake a broader advocacy and support role. NSW also operates a *private* duty lawyer scheme through Legal Aid, to make up for the shortfall in categories of cases earmarked for mandatory representation by Legal Aid policies. Although representation in CTO proceedings is also far from universal in Victoria, the striking feature in NSW is the *low level* of aid, and in the ACT the *lack* of legal representation, for this important category of cases.

In Tasmania, neither the Legal Aid Commission nor community legal centres provide MHT representation, instead relying on student volunteers (AdvocacyTasmania, 2008; Anglicare, May 2007: 7-8). Queensland Legal Aid also rarely appears in the MHT. Instead its specialised mental health unit concentrates on people charged with criminal offences appearing in the Mental Health Court (LAQ, 2008), dealing only with around a dozen MHT matters where key information is withheld from patients (LAQAnnualRep, 2007: 67; personal communication with mental health unit, 17/3/2008).

David Heckendorf (2005: para 16) claimed that ‘only Western Australia has arrangements in place to provide free legal representation to mental health patients’, via Health Department funding of a mental health legal centre. In fact South Australia has a somewhat similar arrangement. In addition to the statutory office of the Public Advocate, s 27 of the *Mental Health Act* 1993 (SA) (and cl 77 of the *Mental Health Bill* 2007) provides free legal representation to people subject to detention orders.

2. Advocacy and Representation as Human ‘Rights’

Two main forms of advocacy are legal representation of patients at MHTs to faithfully give ‘voice’ to their arguments; and systemic advocacy to reduce the stigma of mental illness, boost funding and services, and generally ensure equality of social participation.

a. Human rights and legal representation of consumers at MHT hearings

Human rights norms exert some pressure towards provision of representation before MHTs (Davidson, McCallion and Potter, 2003; Coats, 2004; Carney and Beaupert, 2008). The UN Disability Rights Convention provides a little more focus for such arguments (Kayess and Fogarty, 2007: 25-26), reinforcing access to justice concerns identified by the NSW Law and Justice Foundation (Karras, McCarron, Gray and Ardasinski, 2006: esp Ch 5), but it falls well short of Michael Perlin’s call for universal access to high quality legal representation:

Without the availability of ... counsel, it is virtually impossible to imagine the existence of the bodies of involuntary civil commitment law, right to treatment law, right to refuse treatment law ... that are now taken for granted. Similarly, especially in the area of involuntary civil commitment law, the presence of regular and on-going judicial review has served as a bulwark of protection against arbitrary state action (Perlin, 2007: 341-42).

Perlin argues that increased protection for people with mental illness in general has flowed from the provision of legal representation in individual cases (ibid). One consequence of Perlin’s argument is that good representation is essential to the development of effective protection, even if clients do not always consider legal representation to be useful in their case. Perlin argues that the requirement in Article 12(3) for States Parties to ‘take appropriate measures to

provide access by persons with disabilities to the support they may require in exercising their legal capacity', builds that case for legal representation (ibid).

Certainly this is consistent with the 1991 MI Principles, item 18 of which outlines various procedural safeguards for MHT proceedings, including patients' rights to: choose and appoint a legal representative; request and produce an independent mental health report and any other evidence that is relevant and admissible; obtain copies of the patient's records and any reports or documents to be submitted in the hearing (with exceptions); attend, participate and be heard personally in any hearing; invite a person to attend the hearing (with exceptions); and obtain a written decision and the reasons for it.

b. Systemic advocacy

The UN Disability Rights Convention, however, sets out broader rights and principles, including: access to justice (Article 13); freedom of expression and opinion and to access information (Article 21); and participation in political and social life (Article 29). Such rights and principles call for codification of a broader right to advocacy in relation to decision-making under the Mental Health Acts, rather than simply (legal) representation at MHTs. The *Mental Health (Care and Treatment) Act 2003* (Scotland), and the Danish *Mental Health Act of 1989* (Vestergaard, 1994), exemplify such broader rights to support and representation services to maximise client control over decisions about their care and welfare.

Systemic advocacy to change community culture and raise awareness of the needs of people with mental illness also plays an important part. In Victoria, the MH Legal Centre embraces such a *systemic* advocacy role, enabling it to openly criticize the processes of the Victorian Legal Aid Commission; NSW Legal Aid by contrast appears unable to 'lobby' as effectively, perhaps in part owing to funding limitations.²

² A recent review of the NSW Mental Health Advocacy Service recommended expanding the service's functions to incorporate more systematic policy review and systemic advocacy: John Feneley, *Review of the NSW Legal Aid Commission's Mental Health Advocacy Service*, Legal Aid NSW, 2006, Sydney, p 9.

The World Health Organisation's resource package includes consumer self-help, non-government sector lobbying and systemic advocacy, and other strategies. These strategies aim to change public attitudes, sensitise professionals and service providers to consumer perspectives, and generally promote full participation by consumers in shaping policy and public dialogue (WHO, 2003; Funk, Minoletti, Drew, Taylor and Saraceno, 2006). Australia was one of the countries to pioneer such systemic or personal lay or self-advocacy.

Under the National Mental Health Strategy, the Mental Health Council provided training kits and support to develop lay advocacy skills (MHCA, 1999), such as Victorian Legal Aid Commission's publication *Patients' Rights: A self-help guide to the Victorian Mental Health Act*. Similar initiatives have occurred elsewhere, including under the US mandate in the *Protection and Advocacy for Mentally Ill Individuals Act* 1986 (PL 99-319, as amended in 2000), providing protection and advocacy in mental health facilities, including hospitals, nursing homes, community facilities, board and care homes, homeless shelters, and jails and prisons (42 U.S.C.A. §§10801 to §10851). This is reinforced by a Congressional 'mental health bill of rights' offering an indicative guide for States, covering things such as standards for treatment plans, respect for communications and advocacy rights (42 U.S.C.A. §10841).

Such measures are integral to realisation of the broader rights to support and representation services to maximise client control over decisions about their care and welfare.

C. ADVOCACY AND PARTICIPATION IN PRACTICE

Maria Bisogni (2002: 74) criticised 'some' (inexperienced) NSW lawyers for taking 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—'delicate balance' test—enunciated by Mahoney JA in *Harry v MHRT and anor* [1994] 33 NSWLR 315:

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. Brakel was critical of the excesses of adversarial lawyering, while Victorian mental advocacy protocols favour adherence to the 'instructions' of the person. In the ACT the Public Advocate formerly frequently provided 'best interests' and welfare-oriented advocacy, but a regular representative now no longer appears.

This section examines the experiences of clients, advocates and others concerning advocacy and participation in MHT hearings. Limitations of current legal advocacy, and possible alternative sources of advocacy, are considered, along with ways of improving clients' direct participation in hearings. Fieldwork observations, interviews and focus groups support our argument that a *combination* of advocacy models and other measures are needed to provide the holistic rights protection envisaged by the UN Disability Rights Convention, including fuller engagement *by and with* the client and fuller reception *of* the client's needs in the process.

The questions that arise in a particular case are whether the person has a mental illness and its nature, what the appropriate treatment is, whether the person recognises that illness and whether the person is able to take responsibility for managing that illness and follow the treatment regimen. In determining appropriate treatment there are various issues to weigh up. These include the rights to treatment in 'the least possible restrictive environment and least possible intrusive manner consistent with the effective giving of that care and treatment' (Vic MHA 1986 s 4(2)(a); the prevention of harm to the person or to others in the community; and the aim of remedying the illness or ameliorating its symptoms. Apart from the prevention of harm to others, the over-riding aim is the wellbeing of the person with a diagnosis of mental illness.

Wellbeing is a complex issue: what is the balance between current and future wellbeing; physical, psychiatric, social and psychological wellbeing;

safety and autonomy? As a general rule a person's own preference is taken as the best indicator of subjective wellbeing, but where the person's capacity is affected by mental illness, that may not be taken to be the case.

1. Legal representation: instructions and ethical conflicts

Legal advocates in MHT cases consider themselves in a difficult position because the validity of instructions taken depends on clients' legal competence. If clients believe that they are not mentally ill, that they do not require the prescribed treatment, or are capable of living independently and following the treatment regimen—advocates express concern about their ability to judge the accuracy of those beliefs.

MHTs are likely to take a 'best interests' approach which may conflict with clients' wishes:

We act on client instructions. So if the client says to me, 'This is what I want to argue', we will act on their instructions. So we will argue to the Board what the client's instructions are. We don't act at all on a best interest model, we act on instructions (Interview with Victorian Legal Aid Commission, March 2008).

Victorian advocates recognised this dilemma:

I've seen some interesting tension though, the legal/medical type tension where the medical model is very much best interest so we're worried about what's going to happen with the patient. You've got a client, you're acting on instructions so the most important thing is making sure that their instructions are heard and that you're making an argument, you're making a submission. And they're quite different things and so trying to resolve those tensions and actually advocate for your client in a way that's strategic and useful and yet incorporate that medicalised sort of knowledge as well, because a huge part of the legal argument is actually about whether someone is well enough, whether they fit the criteria (Focus group with Victorian legal aid advocates).

And in NSW:

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 (Interview with NSW advocate).'

In some cases, the client's instructions indicated delusion:

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 to the Board, 'My instructions are that my client is the Virgin Mary. If you believe this we do not have a mental illness' (Interview with Victorian advocate).

In another such case the advocate contributed to shortening the period of committal:

Young boy, 18, 19, can't remember, basically been in hospital since he was 14 ... and he was quite psychotic because he thought he was a vampire. And I couldn't get proper instructions out of him. 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 a day'. The Board agreed with that and they gave the hospital four months, five months, I can't remember, for an early review (Interview with Victorian Legal Aid Commission).

Acting 'on instructions' can thus take on a variety of meanings. It can focus on the client's preference for the outcome of the hearing, such as discharge or continued confinement (the first of the three examples given above), or it can include statements about the person's perceived identity (as in the second example). In a sense, a legal representative can add little to the person's own statements about these issues. However the third example outlined above provides a more nuanced understanding of what following instructions from a mentally ill client can involve. In that case, the lawyer did not emphasise the client's preference for 'looking after himself' or his perceived identity as a 'vampire', but provided independent scrutiny of the file at his client's request. This examination led to greater attention to the long-term plans for his client, and an 'early review'.

In many cases advocates believe clients' competence is seriously under-rated by the MHT. The Victorian MH Legal Centre commented in its 2005-06 Annual Report:

Credibility of clients is a stand out issue in the decision making of the Board. Time and time again, the evidence of clients – particularly when they give evidence that they will take their medication or that they will continue to engage with the treatment team if discharged – are not given any weight by the Board. It is truly astounding how few instances there have been when clients are actually given the benefit of the doubt and considered credible by the Board solely on their own evidence. It has certainly been our experience that clients are far more likely to be discharged from a CTO on the basis of evidence provided by witnesses – who do not have a mental illness – such as family members, friends, doctors and independent psychiatrists (p.7).

There are rare cases in which the advocate believes the client is able to live independently but the client's instructions are to the contrary:

The funny thing is that sometimes you get someone with insight, like I had a chap on Thursday at RPA. He wanted to stay there, otherwise I would have argued there was absolutely no way he should be there... He'd been in the hospital about eight days or something and he got completely lucid, completely rational, completely able to see that he had a problem, completely able to accept it. And I'm thinking, 'Well why does he need to be here?' But he wanted to stay. Those were my instructions (Focus group with NSW legal aid advocates).

In other cases the client gives instructions, such as consenting to continuing admission or a CTO, but alters his or her position at the hearing.

Sometimes it doesn't really make any difference whether you go through the submission beforehand with the client. I had a hearing quite recently where I gave the initial submission and the client who was sitting back with me said, 'Yeah that sounds good', and then they start to question you and the instructions just change completely. I gave the submission that she was happy to be on the CTO, they started questioning her about that and she said, 'No I don't want to be on a CTO, I want to be voluntary' (Focus group with Victorian legal aid advocates).

Yeah, it's just all completely different. But by the same token, by making that initial submission, if the client's instructions to the Board are completely different, the Board will then turn to you and say, 'Well those instructions seem to be quite different from your opening submission, what do you say about that?' You have to be prepared to look the fool...(Focus group with Victorian advocates).

Another issue in taking instructions is where the legal advocate has information withheld from the client, either file or oral information, especially if family members are involved:

So one magistrate gives the family members the opportunity to present their views in the absence of the patient though the solicitor is present (Focus group with NSW advocates).

[W]hen you've got clients who say, 'Oh look, Mum or Dad or sister Jane, they'll support me, they're going to come to the hearing, they're going to give this evidence'. But you get Mum or Dad or sister Jane pulling you aside before the hearing: they don't want to have a bar of any of this. They think that your client's sick. They want them to do what the hospital says, that they're walking this fine line, this duplicitous line between telling the person you're assisting, 'Yes look I'll do whatever you want. We'll do this', just to help them (Focus group with Victorian advocates).

Legal advocates identified a conflict for them between honesty in serving the client and the danger of damaging family relationships.

Similar issues arise around access to client records. Some inpatients said that access was given to their files, while others claimed they were not allowed to see them or that some material was withheld. Advocates were more likely to be given access to files:

And then in terms of access to files through hospital files ... it does make it feel less formalised, which in some ways can be good, but I think in some ways that disadvantages clients on the level of there not being a due process that seems to follow on in every hospital. It might depend on the hospital, it might depend on what processes they've set up, how nice they're feeling on the day, whether they want to give the client access to their file or not, whether they want to give them their report 24 hours before ... or a minute before or maybe just not bother because the client won't read it anyway so why bother ... So it definitely feels much less monitored or something. There's less independence and less scrutiny of those processes, which is the role that I feel that we have to take on to some degree. But then you have to work with the hospital to get them on side as well to make sure that you can do the best job you can. So you're in a difficult position sometimes (Focus group with Victorian advocates).

The Victorian MH Legal Centre claimed that inconsistent access to records was contrary to natural justice for clients and created problems for advocates.

It has been common practice for Mental Health Services to remove material from files prior to a hearing so that the client and their legal representative do not have access to the material. They often then fail to make the necessary application for non-disclosure (MHLC Annual Report 2005-06, p.11).

2. Preparation before the hearing

It is suggested that legal advocates meeting clients only the day before, or on the morning of, the hearing—a common approach by Legal Aid in all three study site jurisdictions—will be ill-equipped in many cases to make a valid judgment on the appropriateness of the orders sought; particularly as there is little time to consider information additional to that in clients' clinical files, or any current clinical reports prepared. As most patients seek release (preferably without a

CTO),³ advocates generally make that submission, but with varying degrees of ‘conviction’—and any lack of conviction is keenly felt by clients.

A majority of NSW clients related negative experiences of legal representation, expressing concerns about access and the quality of representation provided, with insufficient preparation time a primary concern:

So when you were told about the hearing; were you given any support to help to get prepared?

No not really, I didn't see a solicitor until the day. And they only talked to me for about ten, twenty minutes (Consumer interview, NSW, 2007).

That solicitor did take some ‘action’ during the hearing, but their client was left with the impression that their case was not argued with sufficient conviction:

And what did they do when the hearing started?

Oh they just said it would be better if we apply for three months and see how we go. So they put it forward to the magistrate or the Tribunal, three months; and they said no, we'll keep you for six.

From another interview,

And how did that go?

Not very well. They only met me for a couple of minutes. Wrote down a couple of notes about me, what I wanted to do. Do I want to get out, or do I want to stay there, and that was it. It was really brief, really quick.

And so how did they go? How did you feel that they represented you?

Poorly. If they wanted to talk to me and know a bit about me they should come a couple of weeks before the date, sit down and lay it all out on the table for me, tell me my options, what I can do and what I can't do, what we should say and stuff like that (Consumer interview, NSW, 2007).

Lawyers often viewed the short window of a day or so prior to hearings as adequate preparation time, given that clients' situations and clinical opinions may change between admission and review. Earlier meetings were thus seen by some as unnecessary:

[I]f you got instructions say two weeks out, your instructions could dramatically alter in that two weeks, so you need to get instructions and review things as close as possible to the hearing (Focus group, legal advocates, Victoria, 15 August 2006).

³ Of course, clients' wishes vary, with some clients agreeing, or expressing a preference, to remain in hospital or be subject to a CTO: Fieldwork observations, NSW, February 2006.

While admitting the logic of this approach (particularly given limited resources), it is suggested that additional preparation time would in many cases be beneficial.

Another person interviewed was unimpressed with the perceived inadequacy of investigation and preparation of relevant documents prior to the hearing:

And I find that if he was a good legal aid lawyer he'd check with me records and make sure that he'd make more contact with me case manager to make sure all me paperwork's there to be presented at court, so that way I'd get a good fair run in court. Last ... court hearing I had last week, well apparently I didn't even have this paperwork ... from me case manager and there was 8 pieces of paper saying that I did finish me order, and that 8 months that I was off me order I stayed in contact with me case manager. I played along how he wanted me to – like keep in regular contact with them – and then that kind of paperwork wasn't presented before I'd even got brought into the place (Consumer Interview NSW, 2007).

Finding out more about clients' circumstances is likely to improve the quality of representation regardless of whether some factual circumstances change in the interim. It may also allow resolution of issues in dispute and/or persuade medical staff to amend reports or recommendations pre-hearing.

Good preparation can influence the ability of the represented person to participate effectively. Where the lawyer has built up some rapport with the client, the former can provide a guide or intermediary between the tribunal and the client. In this way the legal representative stands not so much 'in place of' the client, but alongside them.

I always repeat the question from the magistrate, never anticipate. Because once I did say, 'He's consenting Your Honour', that was the very beginning, and, 'I never did that ... Who are you? Who do you think you are?' And things like this. So ... now I will say, 'I saw you yesterday, we discussed what was going to happen today. The magistrate wants to hear from you whether you're agreeing to stay for this period'. And that's the only way (Focus group with NSW advocates).

3. Evidence and informality

Legal advocates raised some issues with dealing with disputed evidence at the hearing itself: while informality had many advantages, it could give rise to unfairness through lack of due process and failure to test evidence.

The difficulty we have is that it's sort of inquisitorial process with an adversarial flavour to some extent. So it's all reactionary, so the Tribunal doesn't see itself as an advocate for anybody. It feels for people, but if anything it probably sees itself as a bit of an advocate for the hospital to some extent. So it is not a very good balance between it being a pure inquisitorial arrangement. They're not bound by rules of evidence (Focus group with NSW advocates).

Consumers also expressed doubts:

It's certainly not a pleasant experience and you do feel put down and you do feel victimised ... you feel small. But I guess my biggest problem with the whole thing is that it doesn't feel to me like the real legal system at all. It feels like something that's been knocked up by somebody in a position of power, but not a lawyer, not a doctor (Consumer interview, NSW, 2007).

I still can't get the gist of the court because generally it has to be formal evidence doesn't it? They asked informal questions of my friends. But they wouldn't admit their evidence because they said they spoke about the treatment plan, or I think it was the treatment plan they mentioned ... and the lawyer would not admit (Consumer interview, Queensland, 2006).

Acceptance of hearsay evidence is a particular issue. Often the patient is too overwhelmed to argue against inaccurate evidence or does not have the opportunity. A well prepared advocate might point out problems with lack of evidence, question the basis for the consultant's assumptions or bring in evidence from other sources, and many do.

However, some commented that MHTs do not encourage cross-questioning:

One of my colleagues got into real trouble from the Board because she basically took the real adversarial approach to it, cross-examination. It got to the stage where the psych on the board almost made an official complaint, the Board really hated it. And getting the Board offside by really stringent cross-examination of the doctor is always a bad idea because they then come behind the doctor, especially the psych on the board does (Focus Group with Victorian advocates).

I guess what I meant when I said cross-examine is that I think that you can ask questions of the doctor and it's about your manner in doing it and I think if you do it cleverly ... you can catch them out in a way because you're doing it in a way, you're just, 'Oh you know I'm just wondering, you said something about this before. I just wanted to clarify...'. You can find ways of effectively getting them sometimes to say things that they wouldn't or stuff themselves up a bit, if you do it in a nice kind of a way. I find sometimes that the Board forgets to even give you the opportunity so you have to pipe up (Focus Group with Victorian advocates).

MHTs seem to place great weight on consultant psychiatrist's reports.⁴ Consumers suggest that evidence from case-managers, social workers, registrars and nurses should be used more frequently, because consultant psychiatrists have very little knowledge of their patients, apart from written data from those people who *actually* do deal with them on a day-to-day basis. Consumers also urge more consideration of evidence from family and friends about their social circumstances outside the mental health setting.

[H]e believed the doctors without even asking one question from me wife which is very wrong because of what I mentioned before about he should have an opinion of how me lifestyle is at home and ask me wife 'Have you noticed any difference or changes in the whole year?' 'Has he been the person he has been saying he is?'; and to verify it before listening to a doctor that only sees me once for five minutes once a week (Consumer interview, NSW, 2007).

A lot complain that the MHT looks at 'the illness rather than the person'.

4. Alternative issues for advocacy

We now turn attention to alternative sources and approaches to advocacy—not to undermine the crucial role that legal advocates can play, but to open up discussion about the *range* of advocacy roles that may be needed to improve both legal and social outcomes.

Many patients dispute facts in their files, or comment that adverse incidents are more likely to be recorded than good behaviour and that such incidents can remain on their file for a long period, despite good progress since that time.

[W]hereas the consultant sees me in terms of a file history and so she plucks out every negative event that I have been through and tries to make my case really bad, and tries to portray me as someone who is evil or demonic, and really should be locked up and throw away the key. I feel really powerless, like a child, I feel judged, and abused in a way, because it is too negative, it has none of the positives, it is not balanced. There is no balance in terms of what is the case-manager saying, what is the registrar saying, what are other people saying, what is my family saying, my carer, what are people saying about me at that point in time (Consumer interview, Victoria, 2007).

⁴ This trend was more apparent in Victoria and the ACT than NSW, where a greater array of health worker perspectives – such as social worker perspectives – were more frequently presented.

A number point out that family, friends, social workers, case-managers or personal doctors could provide a more favourable account than that found on file. Some have difficulties in their relationships or communication with doctors or other staff and problems with their medication.

For example, consumers frequently seek arbitration on the level and type of medications prescribed, as many have bad side effects; to appeal against their treatment where there is inter-personal conflict; or to receive broader counselling and support services (a form of 'pushing the boundaries' into the domains of welfare services or treatment: further, Carney, Tait and Beaupert, 2008). Yet the stock response of many MHT panels in NSW and the ACT is that treatment and service delivery questions are outside their brief (a position which may be unduly narrow given the wider implications of statutory prerequisites to compulsory treatment requiring the likely effectiveness of treatment to be considered: Beaupert, 2007).⁵ The Victorian Board is however required to turn its mind to treatment issues as part of its mandatory function to review clients' treatment plans (Vic MHA, s 35A).

Even if tribunal panels themselves do not directly engage with clients concerns about care planning and service delivery, there is nonetheless scope for advocacy outside the confines of hearings, such as negotiating about trial release or other measures with case workers, private doctors and registrars.⁶

5. Consumer advocacy services

Consumer advocacy services generally play a broader and more holistic support role, taking into account their clients' social as well as legal needs and the

⁵ In a recent review of the NSW Mental Health Advocacy Service, Feneley noted that clients' non-legal needs are often directly related to their involuntary status, such as how they can connect with relevant non-legal services, especially if they are without social networks: p 29.

⁶ For example, prior to a hearing during which an application for a protected estates order was to be heard, negotiations between the client, a family member and their social worker, facilitated by the legal advocate, led to a decision that an order was not in fact necessary: Fieldwork observations, NSW, 14 February 2006; see the *Protected Estates Act 1983* (NSW) as regards proceedings to determine whether a financial management orders should be made for involuntary patients.

interaction between the two. Some legal advocates also adopt this more holistic approach, as in some England and Welsh hearings (see, Sarkar and Adshead, 2005: 97), rather than focusing narrowly on the core legal issues.

A NSW legal advocate expanded on what this entails:

So we sidestep the legal criteria to some degree and look at the real issue that is holding things up and ask: can we do something about this? Sometimes the hospitals haven't thought about those issues – there's a default position and not always enough time to get to know the person. We can sometimes help to bridge that gap (Interview, Legal advocate, NSW, 2006).

Consumer advocates employed by a Sydney hospital explained that they undertake a variety of individual and systemic advocacy roles (Focus group, Consumer advocates, NSW, 2007). They did not attend all MHT hearings with their clients, but would do so if specifically requested by clients; instead often performing a supportive role for clients *prior* to hearings, explaining what was likely to be discussed and helping to prepare what they would say at the hearing.

On discovering that many clients did not understand why they were in hospital and certainly did not understand what was going to happen to them next or how they could assert their rights, this consumer network developed a program to inform clients about their rights in a way that would make sense to them. The advocates visit wards on a regular basis to explain to groups of consumers, in plain English, concepts such as 'voluntary' and 'involuntary' status, the MHT's role and avenues of redress.

6. 'Advocacy' from other sources

In many instances, 'advocacy' comes from participants other than legal advocates. A recent NSW report on access to justice for people with mental illnesses documented the invaluable assistance provided by non-legal service providers and lay advocates (Karras, McCarron, Gray and Ardasinski, 2006: 172-181).

Our data indicates a similarly wide spectrum of advocacy and support roles exist in the context of mental health tribunal proceedings. For example, a mother of a person subject to numerous compulsory treatment orders described

herself as a 'very strong advocate for her son', putting this stance down in part to her background as a psychiatric nurse (Interview, NSW, 2006). However, this was not simply a vision of herself, but the way in which she actively presented herself in dealings with both health services and Magistrates. She felt that her presence, rather than that of the Legal Aid lawyer, was critical to ensure her son was not too intimidated by the process and was assisted to gain an understanding of what was going on and better present his views to the panel. In fact, the presiding Magistrate thought that she was her son's solicitor, even though the Legal Aid lawyer was in the room:

The Magistrate said to me, 'Are you Liam's solicitor?' And I said, 'No, I'm his mother and his advocate' (I always put that one in), and I looked to the guy who said, 'Oh, I'm the solicitor'.

When asked what the solicitor contributed to the hearing she responded: 'Not a dicky bird, not a word To be quite frank I don't even know what he was doing there.' A number of clients viewed the attendance of family members during hearings as an essential support for them:

When you know that the hearing might be coming up in six months would you be wanting to contact anyone to support you?

Me Mum... Mum and that's about it (Consumer interview, NSW, 2007).

One person spoke of his psychiatric rehabilitation worker as being extremely helpful in preparing a hearing (Interview, NSW, 2007). He cited his relationship with her as one of his most positive experiences of advocacy. The worker sat with him and listened in a non-judgmental way, though she did not do anything active in relation to the hearing or attend with him. However, she played an important role in helping him to come to terms with the impending hearing. He told her that the order was in his view an unjustified infringement of his rights; in a reaction reminiscent of Maria Bisogni's critique (2002), she said she 'understood where he was coming from', but that his view was unlikely to be accepted by the panel.

Loneliness and lack of a supportive social network were key difficulties confronted by this client, and so he was grateful for the worker's caring and down-to-earth approach:

Yes she was great. She was really nice. And we documented how I felt and I told her the truth, and she was like, 'Well the legal system's never gonna take you seriously'. And I'm like, 'Well I already know that, but like this is how I feel, and please please please help me!' You know, I know a fair bit about the legal system and I know that when you're honest you get results. And I had to be direct with this lady and I said, 'Look this is how it is.' And she actually took me seriously, but she told me that no-one in the legal system would take me seriously. And I already knew that, but I had to get that out there (Consumer interview, NSW, 2007).

This experience lends some support to the argument that being taken seriously and 'given a hearing' leads to satisfaction. Yet there may be important differences depending on the *position* of the body with whom the person is engaging. This community worker did not have the power to actually decide on involuntary treatment.

Even when the engagement is auspiced through the MHT, it is wise not to become too starry-eyed about the *therapeutic* benefits of more extensive conversations involving the person, clinicians, representatives and the Tribunal (see, Brakel, 2007: 486-88); or the benefits of longer-range planning of post-discharge support services and life in general. Tribunals may be quite committed to *promoting* such therapeutic outcomes, as Diesfeld and McKenna found in New Zealand (2006; 2007) but there may be unintended adverse impacts or ethical issues (Arrigo, 2004: 37-38), and any tangible benefits (eg lower rates of readmission or greater compliance with treatment plans) need to be rigorously demonstrated empirically (Myers, 1997).

The most secure foundation for representation—whether legal or lay—in MHT hearings may therefore reside in its role in giving expression to the right to *participation*. Or as others have expressed it, in serving as a vehicle for giving 'voice' to the person affected (Cascardi, Poythress and Hall, 2000).

D. CONCLUSION

At both the *practical* level of impacting on the lived lives and experiences of people exposed to the legal powers to detain or treat contrary to their wishes, and the level of MHT processes designed to ensure *fair processes* and strike a

balance between competing needs for treatment, liberty and so forth (Carney, Tait, Chappell and Beaupert, 2007)—there are a number of questions.

We need to ask whether the main problem is that *legal representation* is too strictly rationed, or too constrained by lack of time to speak to clients before hearings. Or, in Michael Perlin's words (2008), simply too 'inexpert'. Alternatively, is it the Tribunal *setting* or *procedures* which are at fault? If so, is the problem, as we have recently hypothesised (Carney and Beaupert, 2008), that MHTs are too pressured by time, too denuded of necessary clinical and other reports, and increasingly shorn of their multi-member and cross-disciplinary expertise? Or does the problem lie in the more intangible (but very powerful) features such as the tribunal 'culture' as constituted by the attitude and body language of members, the dominance of a medical ethos, the ritual or ceremonial dimensions (Tait, 2003) and the demeanour of clinicians, as writers like Tom Tyler (1996) and others have long postulated?

Do we miss the point entirely perhaps, in assuming that the rights, dignity and long-term interests of consumers with a mental illness lie *within* the law and the legal processes (and advocacy supports to those processes) of bodies like the MHTs? Are the rights that we should instead be concentrating on those that sound in the *service system* and the community, as commentators such as Grundell (2005; 2007) and others have suggested?

These are especially hard questions to answer, not just because the evidence about the impact of 'good' practice within MHTs is so hard to quantify or weigh against competing demands on treatment and support services (Diesfeld and McKenna, 2006; 2007; Vine, 2007), but also because the ability of domestic law—or of human rights instruments—to contribute to securing so-called 'positive' rights of access to services is so bleak (further, Carney, Tait and Beaupert, 2008).

This article has argued that legal representation is a *necessary* component of an acceptable system of mental health review, especially whenever liberty is at stake, but is not a *sufficient* contribution towards creation of

the genuinely participatory review spaces in which consumers can enjoy recognition of their interests in gaining access to high quality services or supports, while avoiding unnecessary restrictions on liberty. While the UN Disability Rights Convention assists in making the case for legal representation and wider participation, it is too diffuse and too weak a standard-setting device to do that on its own. Indeed, within the *health* environment of MHTs and the mental health system, extra-legal and contextual factors dominate.

In making that argument, we certainly do not disavow the critical significance of representation in liberty (Perlin, 1992; Winick, 1999: 42-3) or 'right to refuse treatment' cases (Pearson, 2004: 177). Nor do we gainsay that legal advocacy advances *other* important goals, not least in providing voice for the perspective and interests of the person subject to the order (further, Beaupert, 2008). Good advocates may also facilitate therapeutic and other desirable outcomes (Coats, 2004; Diesfeld and McKenna, 2006; 2007), such as promoting quality treatment and provision of services (Beaupert, 2007; Carney, Tait and Beaupert, 2008).

Rather we have argued that a combination of measures may be required—instead of placing undue store in the capacity of legal representation to effect optimal outcomes for mental health clients—in recognition that decisions by MHTs are made in an inquisitorial rather than adversarial environment, heavily suffused with *medical* cultures which marginalise the law (Richardson and Machin, 2000: 495; Richardson and Genn, [2007]), and also heavily reliant on the adequacy or otherwise of treatment and other support services (Vine, 2007; Carney, 2008; Carney, Tait and Beaupert, 2008).

Systemic advocacy for mental health and structural change to the treatment and support system for mental health consumers is therefore required, along with more extensive resourcing of MHTs and the advocates who assist

people appearing before them—to enable MHTs to take the time⁷ and have the material and multi-member panels to provide high quality decisions on the merits, along with congenial and participatory hearing environments (further, Beaupert, 2007: 221; Carney and Beaupert, 2008).

⁷ Australian MHT hearings are often measured in minutes rather than hours, as is now common in England (Perkins, 2003: 53 [75 minutes]; Dibben, Wong and Hunt, 2005: 301 [160 minutes]), or elsewhere (Lesser, 2007: 38 [routinely exceeding 2 hrs in England, Scotland and Ontario]) (Diesfeld and McKenna, 2006: 101 [1.5 hrs in NZ]).

REFERENCES

- Abel, L.K. and M. Rettig (2006). 'State Statutes Providing for a Right to Counsel in Civil Cases'. *Clearinghouse Review*, [2006](July-August): 245-270.
- AdvocacyTasmania. (2008). 'Mental Health Tribunal Representation Scheme.' <<http://www.advocacytasmania.com.au/MHTRS.htm>> (accessed 12 March 2008).
- Anglicare. (May 2007). 'Strengthening Safeguards and Support; Review of the Mental Health Act 1996.' <http://www.anglicare-tas.org.au/index.php?option=com_docman&task=doc_view&gid=72&Itemid=86> (accessed 12 March 2008).
- Arrigo, B. (2004). 'The Ethics of Therapeutic Jurisprudence: A critical and theoretical enquiry of law, psychology and crime'. *Psychiatry, Psychology and Law*, **11**(1): 23-43.
- Beaupert, F. (2007). 'Mental Health Tribunals: From crisis to quality care?' *Alternative Law Journal*, **32**(4): 219-223, 232.
- Beaupert, F. (2008). 'Mental Health Tribunal Processes and Advocacy Arrangements: "Little wins" are No Small Feat'. *Psychiatry, Psychology and Law*, **15**(2): forthcoming.
- Bisogni, M. (2002). 'What is the Role of a Legal Representative Before the Mental Health Review Tribunal?' *Law Society Journal (NSW)*, **40**(10): 72-74.
- Brakel, S.J. (2007). 'Searching for the Therapy in Therapeutic Jurisprudence'. *New England Journal on Criminal and Civil Confinement*, **33**: 455-499.
- Carney, T. (2008). 'The Mental Health Service Crisis of Neoliberalism—An antipodean perspective'. *International Journal of Law and Psychiatry*, **31**(2): 101-115.
- Carney, T. and F. Beaupert (2008). 'Mental Health Tribunals: Rights drowning in un-"chartered" health waters?' *Australian Journal of Human Rights*, **14**(1): forthcoming.
- Carney, T., D. Tait and F. Beaupert (2008). 'Pushing the Boundaries: Realising rights through mental health tribunal processes?' *Sydney Law Review*: forthcoming (June).
- Carney, T., D. Tait, D. Chappell and F. Beaupert (2007). 'Mental Health Tribunals: "TJ" implications of weighing fairness, freedom, protection and treatment'. *Journal of Judicial Administration*, **17**(1): 46-59.
- Cascardi, M., N.G. Poythress and A. Hall (2000). 'Procedural Justice in the Context of Civil Commitment: An analogue study'. *Behavioural Sciences and the Law*, **18**: 731-740.
- Coats, J.W. (2004). 'Mental Health Review Tribunals and Legal Representation - Equality of arms?' *Psychiatric Bulletin*, **28**: 426.
- Davidson, G., M. McCallion and M. Potter (2003). *Connecting Mental Health and Human Rights*. Northern Ireland Human Rights Commission, Belfast.

- Dibben, C., M.L. Wong and N. Hunt (2005). 'Mental Health Tribunals: An issue for clinical governance'. *Clinical Governance: An International Journal*, **10**(4): 300-303.
- Diesfeld, K. and B. McKenna (2006). 'The Therapeutic Intent of the New Zealand Mental Health Review Tribunal'. *Psychology, Psychiatry & Law*, **13**(1): 100-109.
- Diesfeld, K. and B. McKenna (2007). 'The Unintended Impact of the Therapeutic Intentions of the New Zealand Mental Health Review Tribunal: Therapeutic jurisprudence perspectives'. *Journal of Law and Medicine*, **14**(4): 566-574.
- Funk, M., A. Minoletti, N. Drew, J. Taylor and B. Saraceno (2006). 'Advocacy for Mental Health: Roles for consumer and family organizations and governments'. *Health Promotion International*, **21**(1): 70-75.
- Gable, L. (2007). 'The Proliferation of Human Rights in Global Health Governance'. *Journal of Law, Medicine & Ethics*, **35**(4): 534-544.
- Grundell, E. (2005). 'Psychiatrists' Perceptions of Administrative Review: A Victorian Empirical Study'. *Psychiatry, Psychology and Law*, **12**(1): 68-87.
- Grundell, E. (2007). 'Burden to Benefit? Psychiatric perspectives on the impact of administrative review in Victoria, Australia'. A paper delivered at the conference: *30th Congress of the International Academy of Law and Mental Health*, Padua, Italy, June 2007.
- Heckendorf, D. (2005). 'A Submission to the Senate Select Committee on Mental Health.'
<http://www.aph.gov.au/SENATE/COMMITTEE/mentalhealth_ctte/submissions/sub017.pdf> (accessed 12 March 2008).
- Karras, M., E. McCarron, A. Gray and S. Ardasinski (2006). *On the Edge of Justice: The legal needs of people with a mental illness in NSW*. Sydney, Law and Justice Foundation of NSW.
- Kayess, R. and B. Fogarty (2007). 'The Rights and Dignity of Persons with Disabilities: A United Nations Convention'. *Alternative Law Journal*, **32**(1): 22-27, 60.
- LAC(ACT). (2008). 'Duty Lawyer Services.'
<<http://www.legalaid.canberra.net.au/services.htm>> (accessed 14 March 2008).
- LAQ. (2008). 'Our Services.'
<<http://www.legalaid.qld.gov.au/Services/#representation>> (accessed 13 March 2008).
- LAQAnnualRep (2007). *Annual Report 2006-2007*. Legal Aid Queensland, Brisbane.
- Lesser, J. (2007). *Review and Decision Making for Persons with a Serious Mental Illness: Achieving Best Practice* The Winston Churchill Memorial Trust of Australia, Melbourne.

- MHAS. (2008). 'Mental Health Advocacy Service.' <<http://www.legalaid.nsw.gov.au/asp/index.asp?pgid=514>> (accessed 12 March 2008).
- MHCA. (1999). 'Community Development Project: 'The Kit'.' (accessed 12 March 2008).
- MHRB (2006). *Mental Health Review Board, Annual Report 2005-2006*. Melbourne.
- MHRB(WA) (2006). *Mental Health Review Board Western Australia, Annual Report 2005*. Mental Health Review Board of Western Australia, Perth.
- MHRT(NSW) (2006). *Mental Health Review Tribunal of New South Wales, 2006 Annual Report*. Mental Health Review Tribunal of New South Wales, Sydney.
- Myers, D.H. (1997). 'Mental Health Review Tribunals: A follow-up of reviewed patients'. *British Journal of Psychiatry*, **170**(3): 253-256.
- O'Brien, T.A., G.W. Mellsop, K.P. McDonald and C.B. Ruthe (1995). 'A One Year Analysis of Appeals made to Mental Health Tribunals in New Zealand'. *Australian and New Zealand Journal of Psychiatry*, **29**(4): 661-665.
- Pearson, M. (2004). 'Representing the Mentally Ill: The critical role of advocacy under the Mental Health Act 1986 (Vic)'. *Alternative Law Journal*, **29**(4): 174-177, & 196.
- Perkins, E. (2003). *Decision-Making in Mental Health Review Tribunals*. London, Policy Studies Institute.
- Perlin, M. (1992). 'Fatal Assumption: A critical evaluation of the role of counsel in mental disability cases'. *Law and Human Behaviour*, **16**(1): 39-59.
- Perlin, M. (2007). 'International Human Rights Law and Comparative Mental Disability Law: The universal factors'. *Syracuse Journal of International Law and Commerce*, **34**(Spring): 333-357.
- Perlin, M. (2008). "'I Might Need a Good Lawyer, Could Be Your Funeral, My Trial": Global clinical legal education and the right to counsel in civil commitment cases ' <Social Science Research Network Electronic Paper Collection:<http://ssrn.com/abstract> = 1090997> (accessed 6 March 2008).
- Richardson, G. and H. Genn ([2007]). 'Tribunals in Transition: Resolution or adjudication?' *Public Law*,(Spring): 116-141.
- Richardson, G. and D. Machin (2000). 'Doctors on Tribunals: A confusion of roles'. *British Journal of Psychiatry*, **176**: 110-115.
- Sarkar, S. and G. Adshead (2005). 'Black Robes and White Coats: Who will win the new mental health tribunals?' *British Journal of Psychiatry*, **186**: 96-98.
- Swain, P. (2000). 'Admitted and Detained: Community members and mental health review boards'. *Psychiatry, Psychology and Law*, **7**(1): 79-88.
- Tait, D. (2003). 'The Ritual Environment of the Mental Health Tribunal Hearings: Inquiries and reflections'. *Psychiatry, Psychology and the Law*, **10**(1): 91-96.

- Tyler, T. (1996). 'The Psychological Consequences of Judicial Process: Implications for Civil Commitment Hearings'. In: D. Wexler and B. Winick (ed) *Law In a Therapeutic Key*. Durham, Carolina Academic Press.
- UN. (2007). 'Convention on the Rights of Persons with Disabilities.' <www.un.org/disabilities/convention/> (accessed 25 March 2008).
- Vestergaard, J. (1994). 'The Danish Mental Health Act of 1989: Psychiatric discretion and the new legalism'. *International Journal of Law and Psychiatry*, **17**(2): 191-210.
- Vine, R. (2007). 'Review Boards in a Mainstreamed Environment: A toothless tiger in a bedless desert?' A paper delivered at the conference: *30th Congress of the International Academy of Law and Mental Health*, Padua, Italy, June.
- Wenger, D. and R. Fletcher (1969). 'The Effect of Legal Counsel on Admissions to a State Mental Hospital: A confrontation of professions'. *Journal of Health and Social Behavior*, **10**(1): 66-72.
- Wheeler, R. (2001). 'Mental Health Act Hearings: Community Treatment Orders and Community Counselling Orders'. A paper delivered at the conference: *NGOs Mental Health and Community: Focusing on the future*, Sydney, The Mental Health Coordinating Council (MHCC), South West Sydney Area Health Service and NSW Health (Centre for Mental Health),
- WHO (2003). *Advocacy for Mental Health (Mental health policy and guidance package)*. World Health Organisation, Geneva.
- Winick, B. (1999). 'Therapeutic Jurisprudence and the Civil Commitment Hearing'. *Journal of Contemporary Legal Issues*, **10**: 37-60.
- Winick, B.J. (2005). *Civil Commitment: A Therapeutic Jurisprudence Model*. Durham, North Carolina, Carolina Academic Press.
- Zuckerberg, J. (2007). 'International Human Rights for Mentally Ill Persons: The Ontario experience'. *International Journal of Law and Psychiatry*, **30**(6): 512-529.