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A CRITICAL ANALYSIS OF LEGAL REPRESENTATION IN QUEENSLAND'S MENTAL HEALTH REVIEW TRIBUNAL*

JAKE BUCKINGHAM**

Mental health review tribunals make and review a variety of decisions regarding the care and treatment of individuals who have mental conditions. Each Australian State and Territory has established its own mental health review tribunal as the “gatekeeper” of civil commitment. Queensland is the only Australian jurisdiction to establish both a Mental Health Court and a Mental Health Review Tribunal to decide mental health matters. Queensland recently implemented the Mental Health Act 2016 which mandates that individuals are to be legally represented in certain tribunal proceedings. This paper concludes that the mandatory appointment of legal representatives is an indispensable measure to ensure tribunal proceedings are fair, transparent, and therapeutically beneficial.

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** LLB (Hons I), B Com (Accounting) Graduate, Bond University. I would like to thank Assistant Professor Narelle Bedford for her encouragement and comments for this article. An earlier draft of this article was submitted in fulfilment of the course requirements for LAWS13-610 (Individual Study in Law) at Bond University. Any errors remain my own.

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I INTRODUCTION

Regulation of involuntary psychiatric treatment is an important and evolving area of the law. Historically people with 'mental conditions' faced discrimination and stigmatisation and were denied their legal rights.¹ However, society's attitude has shifted from perceiving mental conditions as a "personal weakness" to a treatable and manageable human experience. Both domestic and international frameworks governing 'involuntary commitment' now recognise and protect the rights of persons with mental conditions from arbitrary detention and unwarranted treatment.²

Legal compliance with the rights of persons who have mental conditions is important when considering that almost half of all Australians will experience degrees of mental conditions at some stage in their life.³ In the 2014/15 financial year, 48 857 people were involuntarily admitted into specialised medical institutions nationwide.⁴ Despite the large number of involuntary admissions, there has been minimal academic analysis on Australia's committal procedure. Each state and territory has established its own mental health legislative regime,⁵ which through their similar provenance share many features.⁶

In Australia, multidisciplinary tribunals are the "gatekeepers" of involuntary commitment.⁷ Queensland is the only jurisdiction to establish a dual committal system comprising of a Mental Health Review Tribunal ('MHRT') and a Mental Health Court

¹ Throughout this paper, no reference will be made to the term 'mental illness'. Rather 'mental condition' is the expression used to describe various mental experiences — or more broadly termed 'human experiences'. Persons who are subject to either a hearing in the Mental Health Review Tribunal or Mental Health Court will be described as 'patients' throughout this paper. The author considers the word 'patient' to be the most neutral and clinically correct term.

² By way of background, 'involuntary commitment', also known as 'civil commitment', is defined as the admission of an individual against their will into a mental healthcare facility to treat a diagnosed mental condition; See generally Terry Carney et al, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment?* (Themis Press, 2011) 4–8.

³ Australian Bureau of Statistics, *National Survey of Mental Health and Wellbeing: Summary of Results, 2007* (23 October 2008)

<<http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4326.0Main%20Features32007>>.

⁴ Australian Institute of Health and Welfare, *Specialised Admitted Mental Health Care Patient Characteristics* (December 2015) Mental Health Services in Australia

<<http://mhsa.aihw.gov.au/services/admitted-patient/specialised-patient-characteristics/>>.

⁵ *Mental Health Act 2016* (Qld); *Mental Health Act 2007* (NSW); *Mental Health Act 2014* (Vic); *Mental Health Act 2009* (SA); *Mental Health Act 2013* (Tas); *Mental Health Act 2014* (WA); *Mental Health Act 2015* (ACT); *Mental Health Act 2016* (NT).

⁶ Danuta Mendelson, 'Mental Health Legislation (Civil) in Australia and China: A Comparative Perspective' (2016) 23 *Journal of Law and Medicine* 762, 767.

⁷ Terry Carney et al, 'Mental Health Tribunals: "TJ" Implications of Weighing Fairness, Freedom, Protection and Treatment' (2007) 17 *Journal of Judicial Administration* 46, 46–7.

(‘MHC’).⁸ These two bodies have slightly different responsibilities. The MHC may, in its original jurisdiction, order involuntary treatment for individuals charged with a criminal offence. The MHC also hears appeals from the MHRT.⁹ The MHRT has a number of functions and must balance several competing rights and interests when making decisions regarding the treatment of patients. On the one hand, there is a need to uphold a person’s right to autonomy and freedom from undue detention and coercive treatment, while on the other hand, it is necessary to ensure both the community and the individual is protected from harm. Queensland recently overhauled its mental health laws in order to strike a more effective balance between these competing rights, as well as to ensure compliance with international best practice. One significant reform is the mandatory appointment of lawyers to represent patients appearing before the MHRT in prescribed circumstances.¹⁰ The legislative reforms also provide that in any type of hearing a person may choose to be represented by a nominated support person.¹¹ This paper aims to examine the effectiveness and desirability of legal representation in MHRT hearings. In doing so, it will be established as to whether legal representation protects individual rights and ensures that the best interests of patients and the community are upheld.

II LEGAL BACKGROUND

A Domestic Human Rights Frameworks

Mental health tribunals are bodies that aim to promote the welfare and the legal rights of persons who are unable, without assistance, to make decisions regarding the treatment of their mental condition. Despite their critical role within the broader mental health regime, mental health tribunals, and their processes, have not been thoroughly examined.¹² The scarcity of research is a consequence of a number of factors. Carney, Tait, and Beaupert assert that, unlike other nations, Australia has minimal jurisprudence in the mental health field because no Bill of Rights has been adopted in national law, and only Victoria and the Australian Capital Territory have recently adopted charters of rights and

⁸ Bernadette McSherry, ‘Hospital Orders for Offenders with Mental Illnesses: An Appropriate Diversionary Option?’ (2009) 16 *Journal of Law and Medicine* 568, 568.

⁹ Queensland Court of Appeal hears appeals from the MHC: See *Mental Health Act 2016* (Qld) ss 21, 29(a), 29(c).

¹⁰ *Mental Health Act 2016* (Qld) s 740.

¹¹ *Ibid* s 739.

¹² Carney et al, ‘Mental Health Tribunals: “TJ” Implications of Weighing Fairness, Freedom, Protection and Treatment’, above n 7, 47.

responsibilities.¹³ However, United States academic Michael Perlin writes, 'civil commitment goes almost unmentioned in legal literature'.¹⁴ Therefore, the scarcity of research in this area also extends to international jurisdictions, such as the United States, which have a constitutionally enshrined Bill of Rights.

B International Human Rights Frameworks

During the 20th century, nations such as Australia have become increasingly cognisant of the need to respect universal human rights. Specifically, Australia's adoption of the *International Covenant on Civil and Political Rights* ('ICCPR')¹⁵ and the *International Covenant on Economic, Social and Cultural Rights* ('ICESCR')¹⁶ compelled legislators and administrators to implement and uphold various universal human rights. Relevant to this paper are the rights to: the highest attainable standard of physical and mental health,¹⁷ due process,¹⁸ a fair trial,¹⁹ and protection against torture and cruel, inhuman, or degrading treatment.²⁰

In 1991, the United Nations developed the *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* ('United Nations Mental Health Principles').²¹ The principles were established as a model of best practice for countries to voluntarily adopt. Pertinent principles, for the purposes of this paper, include: principle 9(1) 'treatment administered in the least restrictive environment', principle 15(1) 'every effort must be made to avoid such involuntary admission',

¹³ Terry Carney, David Tait and Fleur Beaupert, 'Pushing the Boundaries: Realising Rights through Mental Health Tribunal Processes?' (2008) 30 *Sydney Law Review* 329, 336.

¹⁴ Michael Perlin, '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' (2008) 28(1) *Washington University Journal of Law and Policy* 1, 3.

¹⁵ *International Covenant on Civil and Political Rights*, opened for signature 19 December 1966, 999 UNTS 171 (entered into force 23 March 1976) ('ICCPR'); See also *Second Optional Protocol to the International Covenant on Civil and Political Rights*, opened for signature 15 December 1989, 1642 UNTS 414 (entered into force 11 July 1991) ('ICESCR').

¹⁶ *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976).

¹⁷ ICCPR art 12.

¹⁸ *Ibid* art 9.

¹⁹ *Ibid* art 14.

²⁰ *Ibid* art 7.

²¹ *The Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, GA Res 46/119, UN GAOR, 75th plen mtg (17 December 1991).

principle 11(1) 'no treatment shall be given to a patient without his or her informed consent', and principle 11(16) 'right to appeal to judicial body'.

The latter half of the 20th century saw several Australian jurisdictions reform their mental health laws. One crucial reform needed to uphold individual rights and narrow the broad discretion of medical practitioners was the establishment of a framework for the independent review of mental health decision-making. Different jurisdictions have chosen different legal models for reviewing decisions regarding the treatment of individuals' mental conditions. Queensland opted to create a specialised Mental Health Tribunal. The MHRT was originally designed to provide criminal offenders experiencing a mental condition with early access to appropriate treatment and to assess any psychiatric criminal defences, such as unsoundness of the mind.²²

The turn of the last century saw a paradigm shift away from the traditional substituted decision-making model toward a supported decision-making approach.²³ Supported decision-making requires that treatment decisions be made by the persons themselves as often as possible.²⁴ At the same time as this paradigm changes, the academic field of therapeutic jurisprudence began to emerge. Both the supported decision-making approach and therapeutic jurisprudence emphasise the importance of empowering legally incapacitated persons to make decisions regarding their own medical treatment. Reflecting this change, Queensland continued on its path of reform by establishing the MHC in 2002.²⁵ Queensland remains the only Australian jurisdiction to establish a specialised court to hear mental health matters. Queensland's unique and innovative reform to establish the MHC best achieves principle 11(16) of the *United Nations Mental Health Principles* — being the 'right to appeal to a judicial ... authority'. In other Australian jurisdictions, tribunal decisions are appealable to a judicial body, most commonly to the State or Territory Supreme Court.²⁶ This process does accord with principle 11(16);

²² Steve Brown, 'The Mental Health Tribunal of Queensland: A Useful Model for UK Forensic Psychiatry?' (1999) 10(2) *The Journal of Forensic Psychiatry* 325, 328.

²³ Sascha Callaghan and Christopher James Ryan, 'An Evolving Revolution: Evaluating Australia's Compliance with the Convention on the Rights of Persons with Disabilities in Mental Health Law' (2016) 38(2) *UNSW Law Journal* 596, 602.

²⁴ *Mental Health Act 2016* (Qld) s 596.

²⁵ Catherine Holmes, 'Queensland's Mental Health Court' (Speech delivered at the Judicial Conference of Australia, Noosa, 11 October 2014) <<http://www.jca.asn.au/wp-content/uploads/2013/11/Mental-Health-Court-of-Qld-for-JCA-Colloquium-10-14.pdf>>.

²⁶ See, eg, *Mental Health Act 2007* (NSW) s 163; *Mental Health Act 2015* (ACT) s 267.

however, these State and Territory Supreme Courts lack the institutional specialisation that allows the Queensland MHC to rigorously test medical evidence and develop therapeutically beneficial processes that accommodate for the distinct needs of patients.

In 2008, Australia affirmed its commitment to mental health reform by becoming a signatory to the United Nations *Convention of the Rights of Persons with Disabilities* ('CRPD').²⁷ The CRPD's purpose is 'to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity'.²⁸ Relevantly, the CRPD expressly provides for supported decision-making, rather than substituted decision-making,²⁹ and outlines various rights, such as access to justice,³⁰ liberty and security,³¹ and the protection of the integrity of the person.³² The predominate reading of the CRPD is that it advances a highly reformist approach which aims to remove any scope for the 'forced' treatment of individuals, and as such acts as a guide of practice.³³

C Recent Legislative Reforms in Queensland

In 2016, the Queensland Parliament overhauled the State's mental health laws by passing the *Mental Health Act 2016* (Qld) ('the Act'). The new Act replaces the *Mental Health Act 2000* (Qld) and commenced on 5 March 2017.³⁴ The Act aims to strengthen patients' rights and support recovery through a number of substantial reforms. Among the changes are: destigmatising the legislative language,³⁵ providing for better patient rights in terms of informed consent,³⁶ developing treatment criteria that is 'less restrictive',³⁷ inserting

²⁷ *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) art 1 ('CRPD'); See also *Optional Protocol to the Convention on the Rights of Persons with Disabilities*, GA Res 61/106, UN GAOR, 61st sess, 76th plen mtg, Agenda Item 67(b), Supp No 49, UN Doc A/RES/61/106 (24 January 2007, adopted 13 December 2006) annex II; Australia ratified the CRPD in July 2008 and the Optional Protocol in August 2009.

²⁸ CRPD art 1.

²⁹ Ibid art 12.

³⁰ Ibid art 13.

³¹ Ibid art 14.

³² Ibid art 17.

³³ See Callaghan and Ryan, above n 23, 604.

³⁴ See *Mental Health Act 2016* (Qld) s 2; Queensland Department of Health, *About the Mental Health Act 2016* (23 March 2017) Queensland Government <<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act/about>>.

³⁵ For instance, pursuant to s 815 of the Act, 'Involuntary Treatment Orders' are now named 'Treatment Authorities'.

³⁶ A comprehensive definition of 'capacity to consent to be treated' is included in s 14 of the Act.

³⁷ See eg *Mental Health Act 2016* (Qld) s 305.

a stand-alone chapter dealing with the rights of patients,³⁸ and establishing consistent criteria for decisions made by the MHRT.

A detailed analysis of every reform is beyond the scope of this paper. Accordingly, this paper will analyse two specific reforms concerning representation during MHRT hearings. First, the Act requires the MHRT to provide free legal representation for patients in certain prescribed hearings.³⁹ Second, the Act expressly provides that persons subject to any type of hearing may be represented by a nominated support person, a lawyer, or another person.⁴⁰

III GENERAL FUNCTIONS AND PROCEDURES OF THE MERIT

A Overview

The MHRT is an independent body required to make and review decisions about the detention, treatment, and care of people who have a mental condition that impedes their ability to make personally consequential decisions. In essence, the MHRT is an arbiter of the lawfulness of the state to involuntarily treat people for a mental condition.⁴¹

The MHRT has original jurisdiction to hear applications for examination authorities,⁴² the approval of regulated treatment,⁴³ such as electroconvulsive therapy ('ECT'),⁴⁴ and the approval of transfer of particular patients in and out of Queensland.⁴⁵ The MHRT has the jurisdiction to periodically review the continuation of a treatment authority.⁴⁶

The nature, effect, and severity of mental conditions change overtime. Therefore, it is necessary that patients' treatment plans and fitness for trial be periodically reviewed. The MHRT is responsible for undertaking periodic reviews of the MHC's decision to issue

³⁸ *Mental Health Act 2016* (Qld) ch 9 'Rights of Patients'.

³⁹ These prescribed hearings include: when the Attorney-General is represented, hearings concerning minors, and when medical practitioners have applied for involuntary electroconvulsive therapy.

⁴⁰ *Mental Health Act 2016* (Qld) s 739.

⁴¹ Terry Carney, 'Australian Mental Health Tribunals — 'Space' for Rights, Protection, Treatment and Governance' (2012) 35 *International Journal of Law and Psychiatry* 11.

⁴² *Mental Health Act 2016* (Qld) s 28(2)(a); An examination authority authorises a doctor or other listed mental health practitioner to enter premises for the purposes of detaining and involuntarily examining a person in order to decide if a recommendation for assessment should be made: See generally *Mental Health Act 2016* (Qld) pt 8 ch 12.

⁴³ *Ibid* s 28(2)(b).

⁴⁴ *Ibid* pt 9 ch 12.

⁴⁵ *Ibid* pt 10 ch 12 s 28(2)(c).

⁴⁶ See, eg, 'jurisdiction to review' ss 28(1)(a) and 705(1)(a), and 'periodic reviews' ss 413–414.

forensic orders, treatment support orders, as well as the MHC's determination that a person is unfit for trial.⁴⁷ The Act provides when these periodic reviews are to occur.⁴⁸ Additionally, the MHRT undertakes periodic reviews of its own decisions. For instance, the MHRT must review a treatment authority within 28 days after the authority is made and again within six months.⁴⁹ The MHRT also has appeal jurisdiction.⁵⁰ The above overview of the MHRT powers and responsibilities demonstrates that the MHRT is not a one-dimensional administrative body. Rather, the MHRT has a complex jurisdiction to review and make a variety of decisions regarding treatment and care of patients.

B Tribunal Members

Mental health law, including Queensland's Act, requires MHRT members to consider not only legal tests but also any medical and social implications for patients. As Dawson observes, the multidisciplinary structure of the legislation makes reliance on legal perspectives alone for its interpretation problematic.⁵¹ There are three types of tribunal members: a legal member,⁵² a medical member,⁵³ and a community member.⁵⁴ Community members have a wide variety of backgrounds and experiences but cannot be a lawyer or a doctor.⁵⁵ Generally, a community member is a non-government health care professional, a person of Indigenous heritage, or a person from a minority cultural and linguistic background.⁵⁶

The multidisciplinary nature of the MHRT is consistent with the *United Nations Mental Health Principles*. Principle 17 provides that signatory nations must establish a body that impartially and independently reviews domestic mental health law. Principle 17 states

⁴⁷ Ibid s 28(1).

⁴⁸ Ibid s 28(2); The MHRT only reviews a person's fitness for trial if the MHC held that a person's unfitness for trial was not permanent: See *Mental Health Act 2016* (Qld) s 21(5).

⁴⁹ Ibid s 413(1)(a)(b); See further s 413(1)(c)(d) for subsequent reviews.

⁵⁰ Ibid s 705(1)(c).

⁵¹ John Dawson, 'Judicial Review of the Meaning of Mental Disorder' (2003) 10(1) *Psychiatry, Psychology and Law* 164, 169–70.

⁵² *Mental Health Act 2016* (Qld) s 707(4)(a)(i); The member must be an admitted lawyer under s 716(2)(a) of the Act.

⁵³ Ibid s 707(4)(a)(ii); The member must be a psychiatrist under s 716(2)(b) of Act. However, if a psychiatrist is not readily available, then the member may be a doctor.

⁵⁴ Ibid s 707(4)(a)(iii).

⁵⁵ Ibid.

⁵⁶ Queensland Government, *About Our Members* (2017) Mental Health Review Tribunal <https://www.mhrt.qld.gov.au/?page_id=17>; The most recent data indicates that 17 per cent of members were of Indigenous heritage or were from a minority cultural or linguistic group: See Queensland Mental Health Review Tribunal, *Annual Report 2015–16* (4 October 2016) 7.

that the review body 'shall, in formulating its decisions, have the assistance of one or more qualified and independent mental health practitioners and take their advice into account'. It has been suggested that principle 17 may be interpreted as requiring tribunal proceedings to include a medical member.⁵⁷

For all proceedings under the Act, the MHRT must be constituted by at least three but no more than five members.⁵⁸ There must be at least a legal member, a medical member, and a community member for every proceeding.⁵⁹

Under its review jurisdiction, as it is in all proceedings, 'the tribunal must act fairly and according to the substantial merits of the case'.⁶⁰ The usual requirement for the Tribunal to be constituted by not less than three members can be dispensed with in three situations (hearing of an application for an examination authority, proceedings for a review of a treatment authority, or in an application for approval to perform electroconvulsive therapy) but only if the President is satisfied of both criteria specified in the Act.

There is no available data on the amount of single member hearings. However, this paper contends that every effort should be made to ensure all hearings have at least all three types of members. Each member serves a distinct purpose that compliments the expertise of each other member.⁶¹ Legal members are able to synthesise legal arguments and perform complex statutory interpretation which helps ensure the legality of MHRT decisions. Typically, legal members are deeply steeped in human rights law and therefore proactively aim to uphold patient rights. On the other hand, community members broaden the MHRT's practical and social experience, while also aiding patients in coping with the stresses of hearings.⁶² Community members can draw on their extensive experiences with the mental health regime to identify with patients' perspectives and are generally highly knowledgeable about the service standards and institutional practices

⁵⁷ Carney and Beaupert, 'Mental Health Tribunals: Rights Drowning in Un-"Chartered" Health Waters?' (2008) 13(2) *Australian Journal of Human Rights* 181, 198.

⁵⁸ *Mental Health Act 2016* (Qld) s 716(2); For an application for the approval to perform non-ablative neurosurgical procedure, the MHRT must be constituted by five members: See *Mental Health Act 2016* (Qld) s 718.

⁵⁹ *Ibid* s 716(2).

⁶⁰ *Ibid* s 733(2).

⁶¹ Carney et al, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment?*, above n 2, 100–4.

⁶² *Ibid* 102.

of mental healthcare facilities, which enables them to uniquely address patient concerns during hearings. Finally, the medical member acts as a translator by ascribing clinical issues and terminology with legal meaning.⁶³

Given their expertise, medical members are uniquely qualified.⁶⁴ Even though there may be a registered psychiatrist on the Tribunal panel, the MHRT may not impose a condition or order that requires a person to take a particular medication or a particular dosage of medication.⁶⁵ Therefore, in this sense the medical member is, as Richardson and Machin state, an expert, witness, and decision-maker.⁶⁶

The pooling of differing professional skills and perspectives through the presence of all types of members is necessary to safeguard patients' rights and ensure that the MHRT satisfies its statutory obligation to be procedurally fair.⁶⁷ Further, on a practical level, the presence of all three types of members reduces the workload burden, which in turn assists the MHRT in meeting its statutory objective of conducting proceedings as efficiently as possible.⁶⁸ Therefore, if a hearing is not constituted by all three types of members, there is a risk that the hearing would be unfair.

Despite the strengths of multidisciplinary membership, it has been suggested that factors such as value judgments and stigma can undermine the fairness of tribunal hearings.⁶⁹ For example, one study looking at Australian Tribunals found that many patients feel stigmatised during hearings — believing members focus on 'the illness rather than the person'.⁷⁰ Furthermore, it has been posited that the multidisciplinary feature of mental health tribunals can adversely affect compliance with procedural fairness. Richardson and Machin claimed that disciplinary members may favour their own professional background. Although their sample was small, Richardson and Machin's study found that while the aim of a multidisciplinary tribunal is to bring different expertise together, in

⁶³ Ibid 96–8.

⁶⁴ Carney et al, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment?*, above n 2, 96–8.

⁶⁵ See eg, ss 426, 447, 451, 478.

⁶⁶ Genevra Richardson and David Machin, 'Doctors on Tribunals: A Confusion of Roles' (2000) 176 *British Journal of Psychiatry* 110, 110.

⁶⁷ *Mental Health Act 2016* (Qld) s 733.

⁶⁸ Ibid s 733(3)(b).

⁶⁹ See Jill Peay, *Tribunals on Trial: A Study of Decision-Making under the Mental Health Act 1983* (Clarendon Press, 1989) 219.

⁷⁰ Terry Carney et al, 'Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-Dreams?' (2008) 26(2) *Law in Context* 125, 138.

practice, members may favour evidence from their own professional field and be suspicious of submissions derived from other fields.⁷¹ However, without further studies, and in the absence of any evidence relating to Queensland, it is not possible to assume the existence or extent of disciplinary bias in the MHRT.

The statutory criteria for various orders and authorities require consideration of medical evidence. Consequently, both legal and community members rely heavily on the opinion of the medical member. Richardson and Machin found in 2000 that medical members can undermine procedural fairness through the timing and extent of the release of their views, and at times they ‘over-influenced’ the panel as a whole.⁷² This concern is exacerbated if the medical member’s opinion is privately expressed during deliberations.⁷³ In order to minimise the risk of medical members dominating the decision-making process, tribunals should publish reasons for their decisions. Until the commencement of the Queensland Act, the MHRT was unable to publish its decisions. The MHRT now has the discretion to publish redacted reasons that ‘may be used as precedent[s]’.⁷⁴ The publication of decisions will enhance the transparency and public accountability of the MHRT — which in turn will better ensure that the MHRT does not arbitrarily exercise its power. Greater transparency and public accountability will promote public confidence in the MHRT as well as increase public awareness of mental health in general.⁷⁵

The above analysis shows that the medical, social, and legal factors statutorily required to be considered by the MHRT necessitates a multi-disciplinary membership and any possibility of ‘over-influence’ by medical members or indeed any professional is likely to be minimised by the publication of redacted reasons for decisions.

IV MHRT HEARING PROCESS

MHRT hearings aim to be more inquisitorial than adversarial in nature and can be described as quasi-inquisitorial proceedings.⁷⁶ Patients subject to a MHRT proceeding

⁷¹ Richardson and Machin, above n 66, 114.

⁷² Ibid 114-15.

⁷³ Ibid 112.

⁷⁴ *Mental Health Act 2016* (Qld) s 758.

⁷⁵ See generally Alison Smith and Andrew Cople, ‘Transparency in Mental Health: Why Mental Health Tribunals Should Be Required to Publish Reasons’ (2014) 21 *Journal of Law and Medicine* 942.

⁷⁶ See generally Carney et al, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment?*, above n 2.

must be given notice of their right to personally appear at the hearing.⁷⁷ This statutory right accords with article 14(1) of the ICCPR which provides that every person has the right to a fair and public hearing in any suit at law. The MHRT may still conduct all or a part of the proceeding entirely on the basis of documents if the patient does not wish to attend, or be represented by another person at a hearing, or if the patient is not fit to appear.⁷⁸ The MHRT is required to make every reasonable effort to ensure that patients who wish to attend are able to be physically present at hearings; however, in certain circumstances this is not possible. For instance, when performing its periodic review function of forensic orders, the MHRT uses videoconferencing for patients who are serving a custodial sentence.⁷⁹

The default position is that hearings are closed from the public.⁸⁰ The closed nature of MHRT hearings is consistent with the approach of most Australian States and Territories and other comparable international jurisdictions (England, Ireland New Zealand and Scotland).⁸¹ Therapeutic jurisprudence is often cited as a justification for the informal, non-adversarial, and closed nature of tribunal hearings — on the basis that this approach is therapeutically beneficial for patients.⁸²

Oral hearings are not only therapeutically beneficial but are also a vital process in upholding patients' legal rights.⁸³ However, the MHRT's ability to ensure fair hearings is undermined by two main issues: first, the lack of patient attendance and second, the inadequate duration of hearings.

A Patient Attendance

Patients must be present in order to realise the therapeutic benefits of the hearing process. Additionally, the presence of patients greatly improves the fairness of hearings as members are able to question patients about such matters as their desired treatment

⁷⁷ *Mental Health Act 2016* (Qld) ss 735–6.

⁷⁸ *Ibid* s 747.

⁷⁹ *Mental Health Act 2016* (Qld) s 746.

⁸⁰ *Ibid* s 741.

⁸¹ Smith and Caple, above n 75, 944.

⁸² *Ibid* 950.

⁸³ Carney et al, 'Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-Dreams?', above n 70, 129–30.

plan. Patient attendance therefore accords with the supported decision-making model prescribed by the Act.

The positive effect of patient attendance at hearings is illustrated by the fact that a patient who attends a hearing is 10 times more likely to have a treatment authority revoked than a non-attending patient.⁸⁴ In the context of Queensland's MHRT, this finding supports Carney, Tait, Perry, Vernon, and Beaupert's assertion that the fairness of tribunal hearings is dependent on the opportunity of patients to participate during hearings.⁸⁵

Despite the importance of patient attendance, the MHRT's most recent annual report indicates that only 14.4 per cent of inpatients and 27.3 per cent of outpatients attended their hearing.⁸⁶ These low-attendance figures pose a serious challenge for the MHRT to uphold patient rights and make decisions in the best interests of patients' welfare.⁸⁷ The low attendance of hearings is a result of a number of factors. One primary reason is the difficulty in notifying patients of their hearing. This difficulty is illustrated by the fact that the MHRT receives up to 40 'return to sender' hearing notifications per week.⁸⁸ Anecdotal evidence indicates that the deficiency with postal communication is a result of the high mobility of the patient population, increasing homelessness, and reluctance by some patients to open official letters from the government.⁸⁹ In order to address this challenge, the MHRT intends to implement two measures. First, the MHRT will use 'priority post for all notices of hearings and decisions to ensure the statutory timeframes for patient notification can be met'.⁹⁰ Second, the MHRT will make every effort to communicate important information directly to patients' case managers and clinical teams.⁹¹ In its 2015/16 annual report (the final report under Queensland's previous *Mental Health Act*), the MHRT stated: 'It is envisaged that the new legislation will generate much higher

⁸⁴ Queensland Mental Health Review Tribunal, above n 56, 13.

⁸⁵ Carney et al, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment?*, above n 2, 308–16.

⁸⁶ Queensland Mental Health Review Tribunal, above n 56, 17.

⁸⁷ Carney et al, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment?*, above n 2, 140–2, 274–307.

⁸⁸ Queensland Mental Health Review Tribunal, above n 56, 12.

⁸⁹ *Ibid* 12.

⁹⁰ *Ibid* 13.

⁹¹ *Ibid*.

attendance from supporting networks and clinical teams and work is underway to facilitate this during the implementation activities'.⁹²

It remains to be seen whether the commencement and implementation of the Act in March 2017 has increased patient attendance. The MHRT should continue to engage with relevant stakeholders in an effort to find areas of procedural and administrative improvement that will increase patient attendance in accordance with the objectives of the Act — namely the promotion of patient rights through the supported decision-making approach.

B No Queensland Data on the Duration of Hearings

There is a need for further research into the duration of Queensland hearings and whether duration has any bearing on outcomes. While there has been research of this kind into other Australian tribunals, there is no available data about Queensland. This may be significant because Carney and Beaupert found that in other Australian jurisdictions the average mental health tribunal hearing time was one-fifth the hearing time of British mental health tribunals.⁹³ In a related study, Carney found that the median hearing time for Australian mental health tribunals (excluding Queensland) was approximately 20 minutes.⁹⁴ Carney compared this figure to the two-hour median hearing time for the Social Security Division of the Administrative Appeals Tribunal.⁹⁵ Given the complexity of the statutory tests, the sensitiveness and diversity of the patients, and the significance of the legal rights affected by decisions, shorter hearing times may run the risk of undermining fairness. In contrast, longer hearing times carry the potential to better realise the legal, social, and medical goals of review.⁹⁶

However, it should not be implied from this research that longer hearings do not occur or that complex cases do not receive the necessary time to be heard. As Carney explains, 'complex cases do receive the time MHTs believe is warranted, sometimes extending to several hours'.⁹⁷ Still, 'for every extension beyond the median duration of 20 minutes,

⁹² Queensland Mental Health Review Tribunal, above n 56, 13.

⁹³ Carney and Beaupert, above n 57, 193.

⁹⁴ Carney, 'Australian Mental Health Tribunals — 'Space' for Rights, Protection, Treatment and Governance', above n 41, 3.

⁹⁵ *Ibid.*

⁹⁶ Carney and Beaupert, above n 57, 196.

⁹⁷ Carney, above n 41, 3.

there is another case (or cases) which ran for less than the median period'.⁹⁸ In the absence of any available data about Queensland, it is impossible to know whether the MHRT fits the pattern of the other Australian jurisdictions. Therefore, there is a need for further research.

V LEGAL REPRESENTATION AND MHRT HEARINGS

A Overview

Patients have a statutory right of 'support' during hearings.⁹⁹ Specifically, a patient can be represented by a nominated support person, a lawyer, or another person, such as a family member or carer.¹⁰⁰ Alternatively, patients can represent themselves and may choose to be accompanied by one member of the patient's support network.¹⁰¹ Representatives of patients are required to represent a patient's views, wishes, and preferences to the greatest extent possible as well as act in a patient's best interest.¹⁰²

In an effort to increase the number of patients who are legally represented in MHRT hearings, the Act now requires patients be legally represented if the hearing concerns: a patient who is a minor, an application for ECT, a review of a patient's fitness for trial, or if the Attorney-General is represented.¹⁰³ Additionally, the MHRT now has the power to appoint legal representation for a patient if it considers it to be in the patient's best interests.¹⁰⁴ An adult patient can waive the right to be represented if the patient has legal capacity.¹⁰⁵ In this situation the person would have the necessary capacity if they have the 'ability to understand the nature and effect of a decision to waive the right, and the ability to make and communicate the decision'.¹⁰⁶

If the Tribunal decides 'it would be in the person's best interests to be represented at the hearing' or if the Tribunal is required to appoint a representative for the patient under s

⁹⁸ Carney, above n 41, 3.

⁹⁹ *Mental Health Act 2016* (Qld) s 739.

¹⁰⁰ *Ibid* s 739(1).

¹⁰¹ *Ibid* s 739(2); 'Support network' is defined as a patient's nominated support person or a patient's family, carer, or other person: See *Mental Health Act 2016* (Qld) s 739(4).

¹⁰² *Ibid* s 739(3).

¹⁰³ *Ibid* s 740.

¹⁰⁴ *Ibid* s 740(2).

¹⁰⁵ *Ibid* s 740(4).

¹⁰⁶ *Ibid* s 740(5).

740(3), the legal representation is at no cost to the patient.¹⁰⁷ It would be unfair and impractical to require patients to pay for the mandatory appointment of legal representation considering patients' unique vulnerability. Given the vulnerability and usually incapacitated state of patients, in order to ensure proper access to justice, it is necessary that patients are adequately supported via competent representation. While other support persons, such as family members, can provide moral support, the complexity of mental health law means that in general patients should be legally represented in order to ensure a fair and just outcome.

B Legal Representation: Advantages

The recent measure to require legal representation for patients should help to ensure that the MHRT fulfils its purpose to uphold both the welfare and legal rights of patients. Lawyers might 'fully investigate and comprehend a patient's circumstances prior to' a hearing 'leading to critical decision-making between counsel and client as to how best to proceed'.¹⁰⁸ They might also help 'the person to present' any 'counterbalancing' information concerning their medical history or an agency's representation.¹⁰⁹

Lawyers are able to cogently advocate on behalf of patients as well as raise patient concerns with the MHRT.¹¹⁰ In most matters, patients are unable to effectively advocate for themselves.¹¹¹ Patients' inability to effectively self-advocate is attributable to numerous factors, which include but are not limited to: poor communication skills, a general fear of authority, sedative effects of medication, and other cultural or social barriers. Advocacy by lawyers allows patients to participate in the decision-making process about their treatment plan. Through legal representation, the focus of hearings is not only on the statutory criteria of the relevant order, but also the issues of most concern for patients.¹¹² Beaupert and Vernon assert that analysing statutory criteria is the primary focus of tribunal hearings rather than addressing patient concerns. The

¹⁰⁷ Ibid s 740(6).

¹⁰⁸ Fleur Beaupert, 'Mental Health Tribunal Processes and Advocacy Arrangements: "Little Wins" Are No Small Feat' (2009) 16(1) *Psychiatry, Psychology and Law* 90, 96.

¹⁰⁹ Ibid.

¹¹⁰ Ibid 98.

¹¹¹ Carney et al, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment?*, above n 2, 251.

¹¹² Fleur Beaupert and Alikki Vernon, "'Odyssey of Hope": The Role of Carers in Mental Health Care' (2011) 18(1) *Psychiatry, Psychology and Law* 44, 57.

disproportionate focus on statutory criteria is a reason why, as Grundell posited, the positive therapeutic potential of administrative review was under-realised.¹¹³ It has been found that patients believe that tribunals listen to their case more when it was being presented by a legal advocate.¹¹⁴ Therefore, lawyers advocating for patients not only enhances patients' ability to actively participate in hearings but also improves the therapeutic benefits of the review process.

While informality, flexibility, and efficiency are desired in MHRT hearings, these features may result in the inadequate testing of medical evidence.¹¹⁵ A failure to adequately test medical evidence would result in an unfair hearing. Studies have found that tribunals often defer to medical opinion even when the preponderance of evidence showed it to be unsubstantiated.¹¹⁶ A patient's legal representative would be able to argue against the admission of irrelevant or unreliable evidence. Further, a patient's legal representative would be able to question the validity of the treating practitioner's medical report and ensure that the practitioner was able to justify the submitted treatment plan.¹¹⁷ In short, the provision of legal representation would ensure that the MHRT more rigorously tests evidence.

Studies indicate that overall mental health tribunal hearings were longer when patients were legally represented.¹¹⁸ This is because legal representatives would ensure that patient concerns are raised, that sufficient regard is made to statutory criteria, and that medical evidence is properly tested — all of which would naturally lengthen the average duration of hearings.

Increased legal representation also increases the level of systemic advocacy that helps positively change community culture and raises awareness of the needs of people with mental conditions. In Victoria, the Mental Health Legal Centre embraces such a systemic

¹¹³ Erica Grundell, 'Psychiatrists Perceptions of Administrative Review: A Victorian Empirical Study' (2005) 12 *Psychiatry, Psychology and Law* 68, 79; See also Erica Grundell, 'Burden to Benefit? Psychiatric Perspectives on the Impact of Administrative Review in Victoria, Australia' (Paper presented at the 30th Congress of the International Academy of Law and Mental Health, Padua, Italy, June 2007).

¹¹⁴ Carney et al, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment?*, above n 2, 253.

¹¹⁵ Carney et al, 'Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-Dreams?', above n 70, 137–8.

¹¹⁶ Carney et al, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment?*, above n 2, 301.

¹¹⁷ *Ibid* 251, 253.

¹¹⁸ *Ibid* 255.

advocacy role, enabling it to openly criticise the processes of the Victorian Legal Aid Commission.¹¹⁹ The implementation of Queensland's new Act may also result in the establishment of a similar body performing systemic advocacy that highlights areas of future reform. Irrespective of whether a formal advocacy body is established, increased legal representation will ensure that MHRT hearings are more transparent and accountable. This is because lawyers who regularly appear before the MHRT can identify and raise procedural issues with professional bodies, advocacy and welfare groups, the Queensland Government, and the MHRT itself.

This paper argues that legal representation does not infringe patients' rights of self-determination or autonomy as lawyers cannot legally substitute their clients' will with their own. Rather, lawyers extend the communicative capacities of patients during hearings.¹²⁰ Consequently, the provision of legal representation for patients fulfils the aims of supported decision-making, and this is supported by the fact that lawyers are required to follow a client's lawful, proper, and competent instructions.¹²¹ However, an overwhelming number of patients do not have legal capacity and therefore would not be competent to provide lawful or proper instructions. While representing an incapacitated patient may not amount to professional misconduct or unprofessional conduct, lawyers are nevertheless placed in a precarious ethical position.

It has been found that tribunals are critical of lawyers who blatantly follow incompetent instructions — yet these criticisms were directed more at private lawyers rather than lawyers who operated frequently in mental health law.¹²² Furthermore, lawyers are required to act in their client's best interests.¹²³ Therefore, lawyers face a further ethical dilemma as not all instructions are in the best interests of patients.¹²⁴ Specifically, some

¹¹⁹ Carney et al, 'Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-Dreams?', above n 70, 130.

¹²⁰ Carney et al, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment?*, above n 2, 241.

¹²¹ Queensland Law Society, *Australian Solicitors Conduct Rules* (1 June 2012) r 8.

¹²² Carney et al, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment?*, above n 2, 249.

¹²³ Queensland Law Society, *Australian Solicitors Conduct Rules* (1 June 2012) r 4.1.1; *Mental Health Act 2016* (Qld) s 739(3).

¹²⁴ Carney et al, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment?*, above n 2, 250.

lawyers noted the difficulty of having patients not remember or change their instructions during the hearing.¹²⁵

There is strong agreement in the legal profession that more resources are needed to allow for more consultative time with patients prior to hearings. Sufficient preparation time with patients is necessary to ensure that lawyers are able ascertain competent instructions and to properly explain the MHRT's decision-making process and its implications to patients.¹²⁶ In short, sufficient preparation is vital to ensure the reform to mandatorily appoint legal representation is effective in achieving fairer hearings.

Under Queensland's newly implemented Act, the number of legally represented patients will significantly increase. In order to address the ethical dilemmas faced by lawyers and to ensure they are properly equipped to act in the best interests of patients, necessary resources, training, and specialised guidelines must be established — a need which the MHRT President has acknowledged.¹²⁷

C Legal Representation: Disadvantages

In essence, it is contended that legal advocacy is incompatible with the MHRT's institutional architecture and therefore should not be permitted. The principal argument against legal representation is that the adversarial approach taken by some lawyers can be contrary to the spirit of Tribunals as informal, flexible, and hybrid administrative arbiters.¹²⁸ Research concerning the ACT, NSW and Victorian tribunals observed that lawyers at times found it difficult to adopt a less adversarial approach in tribunal hearings given their training and experience in courts.¹²⁹ Adversarial advocacy, whether intended or not by lawyers, may cause medical practitioners to become combative during hearings, which could erode the collaborative nature of hearings that aim to achieve a result in the patient's best interest.¹³⁰

¹²⁵ Ibid 249.

¹²⁶ Ibid 247.

¹²⁷ Queensland Mental Health Review Tribunal, above n 56, 7.

¹²⁸ Carney et al, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment?*, above n 2, 252.

¹²⁹ Ibid 256, 292.

¹³⁰ Ibid 252.

Samuel Jan Brakel claims legal representation is a potentially 'excessive' measure that is based on a false analogy with criminal law.¹³¹ Brakel further contends that the 'adversarial inclination' represented by lawyers may actually interfere with promoting therapeutic outcomes.¹³² The provision of legal representation for patients may result in an 'arms race' where medical practitioners also appoint legal advocates. There is a risk that legal advocates representing both patients and practitioners could result in hearings focusing excessively on legal arguments which may lead to, as Treffert describes, patients 'dying with their rights on'.¹³³

Since the MHRT is required to assess a patient's mental and legal capacity,¹³⁴ legal representation could be viewed as counterproductive to the MHRT's ability to assess capacity and to directly engage with patients.¹³⁵ Furthermore, resource constraints could lead to inadequate training for lawyers and insufficient preparation time with patients. Perlin characterised this issue as 'inexpert representation' and postulated that such representation would cause more harm than good for patients.¹³⁶

VI RECOMMENDATIONS

There is no infallible method to decide or review the course of treatment for patients; however, legal representatives can help ensure that administrative arbiters, such as the MHRT, uphold the rights and welfare of patients. This paper therefore supports the recent statutory change that will see an increase in the number of legally represented patients. Lawyers are best placed to represent and navigate patients through the complexity of the hearing process. Nevertheless, lawyers who represent patients must undertake necessary training in order to effectively communicate and fully understand the unique needs of patients. This training should focus on enhancing greater patient participation

¹³¹ Samuel Jan Brakel, 'Searching for the Therapy in Therapeutic Jurisprudence' (2007) 33 *New England Journal on Criminal and Civil Confinement* 455, 469.

¹³² *Ibid.*

¹³³ See Darold Treffert, 'Dying with Their Rights On' (2006) 130(9) *American Journal of Psychiatry* 1041, 1041.

¹³⁴ See *Mental Health Act 2016* (Qld) s 3(1)(a).

¹³⁵ Carney et al, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment?*, above n 2, 253.

¹³⁶ Perlin, above n 14, 26–9; See also, Carney, et al, 'Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-Dreams?', above n 70, 142.

and respect for self-determination as well as on employing both adversarial and inquisitorial advocacy styles necessary for collaborative decision-making processes.

Social workers are considered part of the treating medical team and are usually employed by the government.¹³⁷ Social workers are therefore generally not suited to providing objective advice — as they are perceived to be too closely connected with the treating practitioners. Nevertheless, social workers and case managers must be engaged by both legal representatives and the MHRT in order to communicate important, and usually statutorily mandated, information to patients and ensure patient attendance at hearings. Equally, support persons must be better engaged in order to ascertain patients' views and preferences and thereby realise the supported decision-making approach. Support persons usually lack expertise in advocacy and would therefore not be a superior substitute to legal representation. Nevertheless, support persons should still be strongly encouraged to attend hearings and provide a statement to the members regarding the health of patients. Support persons are instrumental in achieving a therapeutically beneficial hearing for patients. This is because support persons alleviate patient anxieties and help patients understand the hearing process and its implications. Additionally, support persons can aid the MHRT by providing critical evidence in the form of a testimony. Beaupert and Vernon found that there is reluctance amongst some support persons to attend hearings because 'they are concerned about saying things in front of the [patient], such as how the patient is unable to look after themselves, as this may place unnecessary stress on their relationship'.¹³⁸ This concern could be resolved by allowing support persons to make written submissions to the MHRT — thus allowing support persons to *support* patients at hearings without compromising their relationship with patients.

Within the broader mental health regime, there are patient advocates and consultants as well as community advocates.¹³⁹ While some of these roles are performed by employees of government agencies and non-government organisations, many are volunteers.¹⁴⁰ Community advocates are therefore not a suitable substitute for legal representation as

¹³⁷ Carney et al, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment?*, above n 2, 283.

¹³⁸ Beaupert and Vernon, above n 112, 58.

¹³⁹ Carney et al, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment?*, above n 2, 257–9.

¹⁴⁰ *Ibid.*

the serious duty of representing, assisting, and advising patients is generally too onerous for volunteers. Lawyers, on the other hand, are required to act independently and in accordance with stringent professional duties. Further, lawyers have experience in providing clients with multiple legal options and recommending the best alternative without substituting a client's decision. Therefore, lawyers are better placed to advocate for the interests and welfare of patients — especially in complex cases.

Despite the benefits lawyers can bring to hearings, the customary adversarial approach adopted by lawyers is inappropriate for the MHRT setting. It is recommended that a mixed model of advocacy be universally embraced by lawyers for MHRT hearings. A mixed model of advocacy employs adversarial, inquisitorial, and collaborative styles and includes elements of self-advocacy and systemic advocacy.¹⁴¹ Crucially, it is also recommended that lawyers do not simply follow client instructions but also engage with a variety of stakeholders such as carers, family members, and health care professionals. This approach to advocacy is characterised as 'the middle ground' and the 'delicate balance test' which encompasses the best qualities of both the adversarial and inquisitorial approach.¹⁴² The middle ground approach should not be regarded a strict and rigid approach but rather a flexible and ideal model for advocates to aspire to continually practice.

In order for legal representation to enhance the fairness of hearings, lawyers must be cognisant of patients' unique needs as well as be more nuanced in their advocacy style when appearing before the MHRT. Lawyers should therefore adopt the middle ground approach, and this should be facilitated through the provision of specialised training for those lawyers who do represent patients. Finally, in order to promote consistency, transparency and public accountability as well as increase the MHRT's normative impact, the MHRT should regularly exercise its discretion to publish redacted reasons for decisions. The body of precedent that will grow from this measure will guide, as persuasive authority, both lawyers and the MHRT toward consistency in upholding legal rights and patient welfare.

¹⁴¹ Carney et al, 'Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-Dreams?', above n 70, 125, 141–3.

¹⁴² Ibid 131.

VII CONCLUSION

Mental health tribunals, including Queensland's MHRT, have a complex jurisdiction to make and review decisions regarding the treatment and care of people with mental conditions. When exercising its power, the MHRT must balance several competing rights and interests. In essence, the MHRT must protect patients' legal rights while ensuring patients' welfare is not harmed. While the MHRT performs a crucial role in preventing the arbitrary detention and forced treatment of some of the most vulnerable community members, there is minimal academic analysis of the MHRT — especially regarding its unique relationship with the MHC.

There is near universal academic agreement that oral hearings are fairer than proceedings on the papers. However, the fairness of oral hearings may in some instances be undermined by low patient attendance, the potential for inter-disciplinary flaws, and where there is an unreasonably short hearing duration. Queensland's recent reform to increase the number of legally represented patients will minimise the potential for any risk from these sorts of factors. That is not to say that social workers, support persons, and lay advocates do not have a role to play in MHRT proceedings — as their continued engagement through proceedings is crucial in ensuring both fair and therapeutically beneficial outcomes — but that in legally, complex, and "high-stakes" cases, specialist lawyers are better placed to advocate on behalf of patients. In order to avoid MHRT hearings from becoming too adversarial and therefore less therapeutically beneficial for patients, lawyers who represent patients must be provided with necessary professional training that equips them to effectively communicate and advocate for the needs and wishes of patients. Further, specific ethical guidelines must be drafted that allow for lawyers to act upon instructions from legally incapacitated clients. Greater legal representation will likely enhance the fairness, transparency, and public accountability of MHRT processes and decisions as long as legal representatives adopt the 'middle ground approach'. Queensland's new mental health regime should be welcomed as it strengthens patient rights, uses non-stigmatising language, and better achieves the supported decision-making approach that is promoted by international bodies, such as the United Nations. The reform to mandatorily appoint lawyers for patients in prescribed circumstances should be regarded as another step in better regulating civil commitment.

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