Mental health tribunals: rights drowning in un-'Chartered' health waters?

Terry Carney and Fleur Beaupert*

This article assesses features of mental heath legislation relating to compulsory treatment and mental health tribunal processes against domestic 'Charters' of rights recently enacted in Victoria and the Australian Capital Territory. It is argued that genuinely interdisciplinary, multi-member mental health tribunals are vital to the quality of decision-making, and mental health tribunals should be funded to enable them to spend adequate time assessing the merits of each case in line with civil rights standards for prompt and fair hearings, especially where individual liberty is at stake. Because overseas research demonstrates that mental health is a very special jurisdiction, the article summarises those findings before turning to the human rights implications.

I. Introduction

Mental health tribunals (MHTs) have jurisdiction over both compulsory in-patient orders mandating detention in a mental health facility, and community treatment orders (CTOs) requiring a person to comply with a treatment plan while living in the community (Dawson 2005; Rolfe 2001; Wagle, Levy and Allbright 2002; Wales and Hiday 2006). Involuntary detention under Australian mental health law carries authority to treat — except in Tasmania, where it is presently a question for Guardianship Tribunals or the statutory 'person responsible' (DHHS 2007, 14–18). Hearing times are extremely short in Australia (one-fifth or less of those in Britain), and advocacy and other supports are heavily rationed.

MHTs supposedly guarantee fundamental liberty rights by policing the legislatively determined boundary between voluntary and involuntary treatment for mental illness (Richardson and Genn 2007, 136). Overseas research questions how well MHTs protect such civil rights. In addition, economic efficiency queries their multi-

* Terry Carney, Professor of Law, University of Sydney, and Fleur Beaupert, doctoral candidate, University of Sydney. This research is funded by an ARC Linkage collaborative grant studying the Victorian, New South Wales and Australian Capital Territory tribunals, supported by the Law and Justice Foundation of NSW. Julia Perry and two anonymous referees provided helpful comments on an earlier draft of this article.

member composition and their claim on limited professional and financial resources (Vine 2007).

Because the civil rights boundaries are set by statutory provisions importing clinical concepts and necessarily involving review of clinical and service provision to some degree, multidisciplinary tribunals were established, modelled on British initiatives in 1959 (Perkins 2003a). Section 264 of the previous *Mental Health Act 1990* (NSW) constituted the tribunal as a three-member panel — a lawyer, a psychiatrist and a member with other suitable qualifications and skills — for the conduct of *all* proceedings. Multidisciplinary panels are the paradigmatic model for the exercise of MHT functions. Yet recently, several Australian jurisdictions, including New South Wales, South Australia and Tasmania, allowed or expanded provision for incomplete or single-member panels in certain circumstances (s 150 of the *Mental Health Act 2007* (NSW); s 49 of the *Mental Health Act 1996* (Tas); and r 4(2)(a) and (b) of the *Guardianship and Administration Regulations 1995* (SA)). For example, s 150 of the NSW *Mental Health Act 2007* provides that the MHT is to be constituted by '*one or more members* nominated by the President for the exercise of its functions' (emphasis added).

II. Previous research on the nature of mental health tribunal work

Previous studies (for example, du Fresne 2003; Freckelton 2003a; Rees 2003) on the socio-legal operation of MHTs are reviewed elsewhere (Carney, Tait, Chappell and Beaupert 2007), so this part of the article concentrates on the nature or 'style' of tribunal hearings.

Research in England and Wales revealed the limited normative power of mental health law, with 'health' rather than 'legal' culture most in evidence. Medical symptoms, and psychiatric concepts such as 'insight' (Diesfeld 2003; Diesfeld and Sjöström 2006; Freckelton 2003b), were often more prominent than the statutory tests (Perkins 2003a, 127; Perkins 2003c), and court rulings about mental health law or tribunal procedure had less (though variable) impact than anticipated (Appelbaum 1997; Richardson and Machin 2000b). The most recent UK government-commissioned study dealing with this subject, headed by Elizabeth Perkins, identified a number of features of UK MHT decision-making indicating that natural justice may not be adequately afforded in many cases (Perkins 2003a, 216–18). And both major UK studies to date found that 'pragmatic' considerations at times guided outcomes at the expense of legal and factual ones (Peay 1989, 173–74; Perkins 2003a, 218).

From a legal perspective, these tendencies may be interpreted as a serious weakness, falling short of fundamental standards regarding procedural fairness and the need

for decisions to be based on probative evidence rather than irrelevant considerations (Beaupert 2006; Carney, Tait, Chappell and Beaupert 2007).[1] In many cases, MHT decision-making may well be enhanced by more 'rigorous' application of the law. However, this enterprise is a highly demanding and complex one, the success of which depends on a range of factors, including the complexity of the relevant legislation and the level of resources available to MHTs (Perkins 2003a, 125–28); the capacity to involve others, such as clinicians; and the extent to which individual MHT members can successfully overcome any pre-existing biases about mental illness and bring a truly open mind to each case (Perlin 2000).

As Dawson observes, the 'multidisciplinary structure of the legislation' makes reliance on legal perspectives alone for its interpretation problematic (Dawson 2003, 165). Medical perspectives may at times be thought to exert undue influence on MHT panels (Peay 1989; Perkins 2003a; 2003b; 2003c). From a clinical perspective, however, such findings are welcomed — as respecting clinical evidence and valuing the subjective but professional expertise of clinicians in judging the treatment and other needs of patients (Dawson 2003). Without doubt, however, psychiatrist or medical members of panels play a critical role in assisting panels to interpret provisions of mental health legislation containing clinical concepts and in understanding clinical evidence. Arguably, approaches which over-emphasise the value of either legal or medical perspectives are unduly purist.

Rather than a choice between 'legal' and 'medical' perspectives, both must collaborate in order to effectively apply mental health law — and there is also a crucial third interest in play. Apart from an ability to understand the 'medical implications' of a person's situation (Richardson and Genn 2007, 136), mental health law requires a tripartite partnership involving not only law and medicine, but also the 'social context' within which patients live their lives (Winick 2003, 26). Among other things, this means pursuing the goals of clinical 'accuracy' of decision-making and 'fairness' from the perspective of participants (Mahusky, Reinert and Belcher 2002, 49).

The next part of the article provides an overview of the rights and enforcement mechanisms provided for in the new domestic 'Charters' of rights, created by the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (Victorian Charter) and the *Human Rights Act 2004* (ACT) (ACT Charter). Part IV then reviews whether

1 Based on the 1989 findings about extra-legal factors, Peay queried whether procedural fairness (natural justice) was afforded (Peay 1989, 214). Other 'extra-legal' factors include the phenomena of 'sanism' and 'pretextuality' postulated as stemming from prejudice against mental illness (Perlin 2000).

Australian mental health legislation and tribunal processes meet human rights benchmarks, focusing on the Victorian Charter and the operation of the Mental Health Review Board (the Board) in light of relevant overseas court rulings. In Part V, more detailed consideration is given to whether multi-member tribunals are necessary to conduct fair, competent and independent hearings.

III. What is special about civil and social rights?

The UN Charter and its allied instruments — the so-called 'International Bill of Rights' covering the Universal Declaration of Human Rights (1948) (UDHR), the International Covenant on Civil and Political Rights (1966) (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (1966) (ICESCR) — are the 'core' of a universal human rights system (Steiner and Alston 2000, 136). In Victoria and the Australian Capital Territory, certain civil rights now have domestic standing under human rights legislation. As a shorthand statement, it is often said that civil rights fall into four clusters, covering freedom, respect, equality and dignity (VEOHRC 2007). Both the Victorian and the ACT Charters are ordinary legislation, rather than 'entrenched' legislation such as constitutions, and therefore capable of amendment or supplementation over time.

This legislation can lead to reform of MHT procedure and mental health law where discrepancies are found between the relevant standards and either the substantive law or the procedures adopted in its implementation. Although an Australian government assessment found in 1996 that all Australian jurisdictions had or were in the processes of revising mental health legislation to render it compliant with relevant international instruments (Watchirs and Heesom 1996), subsequent commentary and reports have cast doubt on whether such formal change has resulted in significant improvement in human rights protection in the mental health context (MHCA 2005, 37). Even though other Australian jurisdictions have not to date followed suit (with NSW and Queensland rejecting such calls), 'non-Charter' jurisdictions may not easily ignore adverse rulings on Charter-incompatibility of aspects shared by their own mental health legislation, given the public debate and political pressure that may be generated as a result. Indeed, Western Australia has published the consultation report on its draft Human Rights Bill 2007 (Consultation Committee WA 2007), but will await federal developments, while the Tasmanian Law Reform Institute Report supports a wider version of the Victorian model (TLRI 2007).

Civil versus social rights?

Victoria's *Charter of Human Rights and Responsibilities Act 2006* joins the ACT, with its *Human Rights Act 2004,* in recognising various civil and political rights derived from

the ICCPR and providing certain remedies where laws or public decision-making contravenes those rights. However, both are for the most part silent about economic, social and cultural rights — such as can be found in Art 12 of the ICESCR, recognising 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. The same omission of social and economic rights occurs elsewhere, apart from the largely rhetorical and ambitiously unqualified statements of social rights adopted in parts of post-communist Europe (Sadurski 2002) or the more nuanced balancing of rights against resource and political constraints under the interpretations given to the South African constitution (Koutnatzis 2005, 98).

Traditionally, economic, social and cultural rights have tended to be treated as secondary to civil and political rights, both within the human rights system and by individual states (Alston 1995, 94–95; Gostin and Gable 2004, 99–100). However, there is now an increasing focus on the importance of these rights and the need to promote and protect both sets of rights equally (Gostin and Gable 2004, 99–100; Rosenthal and Sundram 2004). Alston argues that the 'interdependence and indivisibility' of these two sets of rights is one of the fundamental principles of the human rights framework (Alston 1995, 94). This interdependence is visible in a select few overseas human rights court rulings, where certain civil and political rights, in particular the right to freedom from arbitrary deprivation of liberty, have been found very tentatively to give rise to government obligations to comply with minimum standards of care in respect of people 'detained' under state supervision. To date, however, these rulings have been confined to the area of detained prisoners, including those with mental health problems, rather than people subject to compulsory measures, such as detention in hospital, pursuant to mental health legislation (Fennell 1999; Prior 2007).

While this article is primarily confined to consideration of more obvious procedural rights issues arising on the face of the Charters, it is important to keep in mind possible broader implications. Interestingly, the Tasmanian Law Reform Institute Report recommends the *inclusion* of economic, social and cultural rights in a Tasmanian Charter (TLRI 2007, Rec 15, pp 118–22).

The following section outlines the various means by which the Victorian Charter aims to remedy and avert abuses of the relevant civil rights, making some comparisons to the ACT Charter.

Enforcement mechanisms

The enforcement mechanisms in both Victoria and the ACT entail 'soft law' approaches, requiring political and administrative decision-makers to act and to adapt policies so as to avoid contravening human rights standards, along with

monitoring by the relevant Human Rights Commission in each jurisdiction (Victorian Charter, ss 41–42; ACT Charter, s 41) and a narrower set of remedies which may be pursued in court.

Both Charters require scrutiny of all new Bills introduced to Parliament: by the Attorney-General in the ACT and by the member of Parliament introducing the Bill in Victoria, as well as by a standing committee of each Parliament (Victorian Charter, ss 28–30; ACT Charter, ss 37–39). ACT public decision-makers additionally have ongoing obligations to review their compliance with the Charter rights, and must submit annual reports on measures taken to this end (s 45). These mechanisms deliberately eschew litigious pathways in favour of a dialogue model, intended to bring about lasting cultural change in public decision-making through soft suasion rather than binding determinations, where problematic laws and practices come to light (ACT DJCS 2007; Evans and Evans 2006; Williams 2006).

As for 'enforcement' through court processes, one way in which the Victorian and ACT Charters may impact on the work of the Board and ACT Mental Health Review Tribunal is through Supreme Court declarations of 'inconsistent interpretation' or incompatibility between the relevant Charter and mental health statute. Such declarations are not, however, binding and simply require Parliament to reconsider the wisdom of its original provision. Once properly raised in proceedings, the rights are not unlimited, but are subject to 'reasonable limits' able to be justified in a 'free and democratic society based on human dignity, equality and freedom' (Victorian Charter, s 7(2); ACT Charter, s 28), elaborated under s 7(2)(a)–(e) of the Victorian Charter, paying regard to certain stipulated factors, such as the nature and purpose of the right and any limitation of it.

The Victorian Charter also provides a more direct enforcement mechanism in respect of the Board's 'administrative functions'.

The statutory construction requirement and Supreme Court declarations of incompatibility or 'inconsistent interpretation'

The 'dialogue model' favoured by the Charters is evident in the new rules of statutory construction requiring 'all statutory provisions' (in the case of Victoria) and 'all laws' (in the case of the ACT) to be interpreted in a fashion consistent with the recognised human rights as far as possible (Victorian Charter, s 32; ACT Charter, s 30). This mandate applies to all who implement the law, including the relevant MHTs and others who exercise functions under mental health legislation, such as clinicians. Although it does not give rise to a new cause of action, it may found a legal remedy where statutory interpretation is at issue (Evans and Evans 2006, 267).

The Victorian Charter provides for a more direct route to resolve any dispute as to statutory construction relating to the Charter. If a question of law in this vein arises during proceedings of the Board, the matter may be referred to the Supreme Court by the Board on application by a party to the proceedings (s 33). Thus, a party to a Board hearing could apply to refer a question of law concerning interpretation of the *Mental Health Act 1986* (Vic) (MHA Vic) consistent with the Charter to the Supreme Court. Presumably, if the Board determined that the matter was not appropriate for referral, the statutory construction mandate in s 32, coupled with relevant rights listed in the Charter, may be relied on to seek a remedy at an appellate level.

In Victoria, the only legal remedy is a 'declaration of inconsistent interpretation' by the Victorian Supreme Court (Victorian Charter, s 36) where a question of statutory construction vis-a-vis the Charter arises during proceedings of that court.[2] Such a declaration requires the relevant Attorney-General to table a written response within six months of its issue (Victorian Charter, s 37; similarly, ACT Charter, s 33). Declarations of incompatibility under the equivalent British statutory construction provision have been infrequent (15 instances since October 2000, with another five reversed on appeal: Clayton 2007, 13), but three of these were mental health cases (Gledhill 2007, 385) and in other instances the courts have re-interpreted legislation so as to render it compatible with human rights.

The Victorian obligation on the Mental Health Review Board to comply with human rights in the exercise of 'administrative functions'

The alternative, more clear-cut, mechanism to enforce human rights protection using the courts is found in s 38 of the Victorian Charter, which makes it unlawful for public authorities to act in a fashion incompatible with a human right or to fail to give proper consideration to a human right. This provision impacts on the *administrative functions* of the Board, such as in listing cases or determining its procedures. This is because the definition of a 'public authority' does not include a court or tribunal, *other than* when it is 'acting in an administrative capacity' (s 4(1)(j)). This provision — which also impacts on functions exercised by other public officers, such as clinicians, pursuant to mental health legislation — is the most certain means

2 In the ACT, the comparable provision allows for the Supreme Court to make a 'declaration of incompatibility' (s 32). In Victoria, the relevant Attorney-General and Human Rights Commissioner is entitled to intervene (Victorian Charter, ss 35a and 36(4)). In the ACT, there is a broader right for the comparable parties to intervene (ss 35–36), whereas in Victoria, only the Attorney-General has a right to intervene in any such *court or tribunal proceeding*.

of securing a legal remedy on the ground of unlawfulness arising out of the Charter as prescribed in s 39. Such relief may only be sought, however, if there is a pre-existing cause of action in respect of a decision or act of a public authority (s 39(1); see further on judicial remedies Evans and Evans 2006, 274–80).

Notably, although the Victorian Charter does not carry *new* monetary or other remedies (Evans and Evans 2006), the ACT Charter expressly includes, among the recognised human rights, a right to compensation for unlawful arrest or detention and for wrongful conviction (ACT, ss 18(7) and 23).

IV. Implications of the Victorian Charter for MHTs and mental health law

Because it subscribes more closely to a 'clinical control' than a 'due process' model of mental health legislation, Victorian law potentially rubs up against Charter rights to a greater extent than is the case in other Australian jurisdictions. The Victorian example is now used to illustrate possible human rights arguments regarding inconsistency between the Charter and either the provisions of mental health legislation or the 'administrative functions' of the Board and other public authorities exercising functions under the MHA Vic.

The human rights sounding most strongly here are those to freedom from arbitrary deprivation of liberty and to a 'fair hearing' (s 24(1)). Others with obvious, although less clear-cut, implications in the mental health context are the right to freedom from torture (and experimentation and treatment without consent: s 10), the right to be treated humanely when deprived of liberty (s 22(1))[3] and the right to freedom from discrimination and equal protection of the law (s 8).

The right to liberty: prompt advice and determination of lawfulness

Section 21 of the Victorian Charter (dealing with the right to liberty and security of the person) is the most obvious candidate to rely on to argue that the provisions of mental health legislation relating to compulsory treatment are inconsistent with those of the Charter. This provision precludes deprivation of liberty except 'on grounds established by law and in accordance with procedures established by law'; requires prompt notice to be given of the reasons for the deprivation; and effectively

3 This section provides that '[a]ll persons deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person'.

provides for the writ of habeas corpus in making provision for prompt determination of the lawfulness of any deprivation of liberty by a court.

First, this section requires all who have been detained and arrested to be advised promptly of the basis for their preliminary detention. All Australian mental health statutes now require individuals detained to be promptly provided with information about their rights and pending MHT review proceedings (for example, MHA NSW, ss 74, 76 and 77; MHA ACT, s 50; MHA Vic, s 18). It is mental health service staff that must implement these requirements. A failing in relation to the provision of prompt notice, such as where a translation into a language the person understands has not been provided, could potentially amount to unlawful conduct by a public authority (the health service). Despite statutory obligations to provide written and oral statements of patient rights, it was found in 2001 that 30 per cent of Victorian patients did not know that they could access information before the Board or appeal their involuntary status; that many found it difficult to access such information; and that about half did not know about legal representation (Auditor-General of Victoria 2002).

Second, Victorian mental health law is vulnerable to challenge because *clinicians* make initial admissions (as is also the case in Tasmania, SA and WA),[4] and the outer limit on initial Tribunal review of admissions is a generous eight-week period (s 30(1)).[5] In other words, after being involuntarily detained in a health facility, the Board may not review a person's circumstances to determine whether their

4 *Mental Health Act 1986* (Vic), ss 9, 12, 12AC and 14 (clinicians may make a CTO for an involuntary patient); *Mental Health Act 1996* (Tas), s 29; *Mental Health Act 1993* (SA), s 12; *Mental Health Act 1996* (WA), s 43.

5 However, the Victorian Board attempts to schedule hearings sooner than the eight-week limit. South Australian clinicians authorise up to six weeks' detention before review (MHA SA, s 12), while Tasmania allows one month (MHA Tas, s 52). By contrast, NT detention or CTO orders are to be reviewed within seven days (*Mental Health and Related Services Act* (NT), ss 39(1), 45(3) and 123). In NSW admissions are reviewed by a magistrate 'as soon as practicable' after obtaining a second medical opinion (MHA NSW, s 27(d)). Following 'mental health inquiries', the magistrate must discharge if the grounds are not satisfied, but otherwise may make orders for initial involuntary observation or treatment (or both) for up to three months (s 35(5)(c)), or release on a CTO or into the hands of a 'primary carer' (ss 35(5), (b) and (a), respectively). The MHT must review all applications for extension (ss 37(1)(a) and 37(2)) and do so every three months thereafter during the first 12 months (s 37(1)(b)) and then six-monthly (s 37(1)(c)). In the ACT, other than in emergencies, involuntary treatment can only *commence* by way of a tribunal order.

continued detention is warranted for up to eight weeks. Only WA shares this maximum timeframe (MHA WA, ss 48 and 138(2)). The comparable provisions of the European Convention, Arts 5(1) and 5(4), founded the British ruling that 'routinely delaying' reviews for eight weeks breached the 'prompt presentment' principle (Gledhill 2007, 398; *R (C) v London and South and West Region Mental Health Review Tribunal*, 2002). Breach of the speedy hearing rule was one of the three cases awarded damages (Clayton 2007, 26), a remedy not available as such under the Victorian Charter (Evans and Evans 2006, 274ff).

Declarations of inconsistency have also been made in other areas on this ground in overseas jurisdictions. Thus, two provisions of the UK *Mental Health Act 1983* were found to be inconsistent with human rights principles for effectively requiring the *patient* to show that their detention was not warranted, rather than requiring the state to establish continuing satisfaction of the statutory criteria (Bindman, Maingay and Szmukler 2003, 91). Other declarations were made in respect of the rules for changing the 'nearest relative' (who exercises various consultative and other roles, but who may not have the confidence of patients) and the burden of proof for release (Gledhill 2007, 385–89).

Human rights challenges may also impact collateral rights, such as to representation. Thus, the right to a quick hearing and to be discharged if applications for detention cannot be sustained at hearing — as provided under the UK *Human Rights Act 1998* and the European Convention on Human Rights and Fundamental Freedoms — is credited in Britain with the extension of legal representation even to patients who do not request it (Coats 2004), based on the earlier European Court of Human Rights ruling in *Megyeri v Germany*, 1993. Indeed, the Northern Ireland Human Rights Commission suggests that this ruling impels provision of both legal advice and (for Australia, retention of) automatic hearings (Davidson, McCallion and Potter 2003, 41). Currently, free legal representation in involuntary detention review in Victoria is provided on a merits basis and legal representation during Board hearings is rare (5–10 per cent in Victoria: Lesser 2007, 12).

Resource constraints have not constituted a sufficient answer to such breaches in overseas rulings. Operational reasons, such as lack of sufficient medical members to enable prompt listings, did not excuse the breach found in *R (KB and others) v Mental Health Review Tribunal*, 2002, and a lack of adequate case-management systems failed to excuse the breach found in *R (B) v Mental Health Review Tribunal*, 2002.

The right to a 'fair' hearing

The right to a 'fair' hearing in a civil hearing requires determination by 'a competent, independent and impartial court or tribunal' after a 'fair and public hearing'. This

may give rise to Charter-based arguments deriving from either the statutory construction mandate or the s 38(1) obligations on public authorities (compare ACT Charter, s 21).

A number of relevant procedural standards already appear in the legislation (Rees 2003; Watchirs 2000), such as the Victorian and ACT requirements to comply with the rules of natural justice (MHA Vic, s 24(1)(b); MHA ACT, s 96). Victorian law also provides patients and their representatives rights of access to documents relevant to their hearing, and NSW permits access to medical records prior to hearings.[6] These are not unqualified rights, however, since information may be withheld where its disclosure may be harmful. The width of those exceptions may fall foul of the Charter, even though they are more tightly drafted than the equivalent provisions condemned by the Northern Ireland Human Rights Commission (Davidson, McCallion and Potter 2003, 42). However, overseas rulings on this issue vary: the court jurisprudence in Europe has leant heavily in favour of endorsing clinical practices (Bindman, Maingay and Szmukler 2003, 92; Gostin 2000).

In addition, certain less tangible practices of MHTs may well limit the 'fairness' of hearings, conceived broadly, but may prove difficult to uncover or to articulate as contravening Charter rights. For example, UK studies pointed out that canvassing critical evidence before or after hearings, without disclosure at the hearing (or in the reasons), may breach procedural fairness, as might reliance on woolly concepts like 'insight' (Peay 1989, 212, 105), or reasoning by hypothesis (Perkins 2003a, 52). Such practices raise difficult questions about the best way to achieve effective protection of human rights as affected by MHT policy and culture that cannot be easily pinned down and slotted into the terms of the Charter.

It is contended that challenges to the use of incomplete panels have a reasonably sturdy foundation in the Charter right to a fair hearing, and that public authorities should certainly interpret mental health legislation and undertake law reform cognisant of the value of genuinely multidisciplinary decision-making in the mental health context. This question requires consideration of the practical implications of MHT panel composition and the adequacy of the resources and time within which they operate, addressed in Part V of this article.

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6 MHA Vic, s 26(8)(a) (serious harm to health); *Mental Health Act 2007* (NSW), s 156 (disclosure is subject to tribunal orders: s 156(1); and report writers may include 'warnings' which serve to avoid the need for disclosure of certain information: s 156(3)). Victoria also excepts unreasonable disclosure of personal affairs or breach of confidentiality terms: s 28(8)(b) and (c).

V. What is special about tribunals, and MHTS in particular?

Tribunals in Australia rapidly moved from the experimental to the mainstream (Mendelsohn and Maher 1994), following endorsement by bodies such as the Kerr committee (Commonwealth Administrative Review Committee) in 1971. Unlike Britain, which rejected the idea of tribunals as 'appendages' of the executive, Australia accepted tribunals with executive as well as strictly 'judicial' functions (Richardson and Genn 2007, 116–17).

Advantages of flexibility and informality of procedure, speed and cost, the ability to locate expertise 'in-house' on the tribunal (Richardson and Genn 2007, 117), psychological informality and architectural 'accessibility', interdisciplinarity, the capacity to deal with high volumes of cases and presumed greater 'normative' power in respect of primary decision-makers are among many justifications for preferring tribunals over traditional courts or the various other ways of achieving adjudicative or qualitative outcomes. However, this variety of functions and forms of 'tribunal' review conceals a number of very important distinctions and issues of principle.

Taking the mantra of 'proportionate dispute resolution' of the British government's 2004 white paper as their hook, Genevra Richardson and Hazel Genn (2007) re-examine the importance of 'independence' and an oral hearing within three broad types of tribunals: those concerned with 'fundamental' rights (such as mental health detention); those concerned with entitlements to 'material benefits' (such as income security); and those designed to ensure an 'assessment' or a 'consideration' of access to government largesse, such as special needs education or services — as under Victoria's former Intellectual Disability Review Panel (IDRP 2007) or Britain's Special Education Needs and Disability Tribunal (Richardson and Genn 2007, 138).

Richardson and Genn argue that these are polar extremes, with independence and oral hearings being absolutely *vital* constituents of hearings impacting on civil rights protection, but otherwise arguably more dispensable in other settings. This immediately poses a serious human rights challenge for Australian MHTs, where attendance by proposed patients at hearings is modest (approximately 60 per cent in Victoria) and legal representation rare, as discussed above (5–10 per cent in Victoria: Lesser 2007, 12).[7] Even attendance by the key clinician may be unusual, with junior staff interpreting clinical notes instead. In a similar vein, we argue that a related

7 Based on recent annual reports, similar rates (at 8.3 per cent) are found in WA (MHRB WA 2006). Legal representation was higher in NSW in 2006 (16.2 per cent in 2006), but mostly for inpatient rather than CTO reviews (MHRT NSW 2007).

challenge to the guarantee of fundamental rights in mental health is the question of multidisciplinary hearings. This is because the criteria distinguishing between lawful and unlawful detention *necessarily* import clinical concepts (Richardson and Genn 2007, 126; Richardson and Machin 2000a).

The definition of 'mental illness' in particular, the presence of which is generally one of the criteria for compulsory treatment, refers to clinical concepts such as 'hallucinations' and 'delusions'. For example, NSW, ACT and NT mental health legislation contains almost identical definitions of mental illness: a condition seriously impairing mental functioning involving symptoms such as 'delusions', 'hallucinations' and 'serious disorder of thought form' (MHA ACT, s 4; MHA NSW, Sch 1; MHA NT, s 6). Victoria expressly refers to mental illness as a *medical* condition (MHA Vic, s 8(1A)), while the NT additionally refers to internationally accepted clinical standards (MHA NT, s 6(2)). Additional criteria, such as a person's 'need for treatment to prevent harm', and the 'least restrictive' treatment environment (MHA Vic, s 8; MHA NSW, ss 14 and 37; MHA ACT, s 28; MHA SA, s 13; MHA NT, s 14; MHA Tas, s 24; MHA WA, s 26), similarly require some deference to the opinions of health workers. In other words, the story of when a person can lawfully be detained due to mental illness is held and understood not in a legal environment, but in a clinical or *health* environment.

Although the United States, The Netherlands, Denmark and Ontario, Canada wholly or partially rely on lawyers or courts to read and apply these 'texts' and, as explained below, up to one-fifth of Victorian Board hearings are conducted by single members (Lesser 2007, 37, 12), it is the difficulty of *accurately* and *fairly* reading this text (and interpreting clinical information) that is the rationale behind multi-member tribunals, and the genesis of the human rights critique of any departure from this configuration. Certainly, one cannot discount the valuable work that time-pressed mental health tribunals do in verifying to *some degree* the legal accuracy of decisions to section patients as involuntary, or in accelerating some pre-hearing discharges by concentrating the mind of clinicians. However, there is some substance in Bruce Winick's complaint about the 'basic dishonesty' of superficial or 'peripheral' processes of review which fail to engage the clinical evidence founding committal (Winick 2005, 145), achieving little more than giving an *appearance* of auditing the justifications for involuntary detention and treatment, with negligible overruling of admissions. At its core, Winick's charge, as we would re-interpret it, is that debased processes of MHT review fall foul of civil rights obligations for prompt, independent and fair hearings, and also fail to realise the social rights of patients. Effective realisation of relevant social rights — above all, the human right to health — depends upon the capacity or otherwise of MHTs to *engage* with the clinical evidence, and the *health domain* central to deciding whether detention is warranted.

It is, of course, quite *conceivable* that more modest 'mere superficial auditing' outcomes may be all that is sought by public policy. Such results may equally be realised by official single-member tribunals (as in SA),[8] or even de facto single-member panels (where presiding lawyers consign other members to what Professor Kathleen Bell, writing in 1975 about the Supplementary Benefits Appeal Tribunals in the UK, once termed 'decorative book-ends': Bell 1975). But if that is all that is sought, would it not be better (and more honest) to call it a 'merits review *court*' (on all fours with, say, 'problem solving' courts: Freiberg 2002/03; Indermaur and Roberts 2003), rather than maintain the charade that it is a tribunal? Certainly, that complaint can be made of the jurisdiction of the Victorian Civil and Administrative Tribunal (VCAT) in guardianship matters, or the late 1990s transformation of British social security tribunals (Wikely 2000). The complaint can also be made about the empowering, since 1997, of some single- or two-member hearings for NSW Guardianship Tribunals under s 51A of the *Guardianship Act 1987* (originally for procedural issues, but very significantly broadened to 'reviews' of guardianship or administration orders in mid 2007).[9]

Multi-member MHT panels are generally retained in Victoria and the ACT. Although the Victorian Board generally comprises three members, single members (from any membership category) can sit on annual reviews, reviews of interstate transfer orders or extensions of CTOs (MHA Vic, Sch 2, r 1(1A)). ACT panels comprise three members for involuntary admission, ECT and forensic matters, but otherwise comprise a presidential, lawyer member only (MHA ACT, ss 83(1) and (2)). However, the changes authorised by the NSW *Mental Health Act 2007* signify a potentially drastic move away from multidisciplinary three-member panels — depending upon how the relevant provisions are implemented by the MHT President. The new Act

8 The SA Guardianship Board (MHA SA, s 3) reviews all initial and discharge applications (ss 25, 26). Mental health panels constituted under s 6(3) of the SA *Guardianship and Administration Act 1993* include at least one psychiatrist (s 6(4)). The regulations authorise one- or two-member mental health panels (*Guardianship and Administration Regulations 1995*, r 4(2)(a),(b)). While guardianships must be heard by three members, this is not the case for mental health. On economic grounds, the Board decided that *single* members (of any background) would hear *all* mental health cases (discussion with Barbara Robertson, Registrar, Guardianship Board, 4 July 2007). In Victoria, three-member panels are mandated in all except periodic reviews, and extensions of CTOs (where one to three members can sit, without any disciplinary preference): MHA Vic, Sch 2, cl 1A.

9 The Second Reading speech by Minister Kristina Keneally explained that 'simple medical decisions can be made by a one- or two-member tribunal without disadvantage to the person with the disability' (NSW Parliament 2007, 468).

merely provides that panels must include the President, the Deputy President or a legal practitioner (MHA NSW, s 150(1) and (2)). The inclusion of psychiatrists or community members (or both), however, is optional (s 150(3)), though regulations may prescribe particular memberships for particular functions (s 150(5)).

We strongly contest debasement of the functions of MHTs, arguing that properly resourced interdisciplinary and multi-member hearings should be retained for the reasons set out below.

Limits to the 'inquisitorial' brief of mental health tribunals?

Australian MHTs are not *predicated* on the adversarial model, or upon an obligation for the state to 'prove' its case as such. Instead, they operate as inquisitorial bodies, charged with making up their own mind about the question, and ensuring a sufficient understanding to reach the requisite state of 'satisfaction' on which to found a decision (by contrast, US law imposes a quasi-criminal standard: Appelbaum 1997). Of course, these qualities of an ideal 'inquisitorial' model may not be discernable at the practical or operational level. In place of supposedly inquisitorial and informal hearings, the Victorian Auditor-General found low rates of patient attendance (just 38 per cent in 2001, rising to a reported 57 per cent in 2006: MHRB Vic 2006, 31), with many clients reportedly confused, powerless and intimidated by the processes (Auditor-General 2002, 111).

Whether or not tribunals can in fact ascertain the 'truth' of the matter depends partly on the capacity and willingness of service providers to provide up-to-date and accurate information about the various relevant health and social factors, in addition to whether or not MHT panels actively seek out such information. There are concerns across jurisdictions that both the written and the oral information provided by clinicians to tribunals lacks currency or direct familiarity with the client in question. For example, the 2005 *Annual Report* of the WA Mental Health Review Board states:

> In some cases no member of the treating team with up-to-date information about the patient's progress and current situation is available at the hearing to provide information needed by Board members in order to make an informed decision about the patient's involuntary status. [MHRB 2006, 10.]

The report goes on to note that this state of affairs was likely due to the under-resourced state of many health service agencies.

A major constraint on the ability of Australian MHTs to gather information (and of health service professionals and others to provide it), then, may be the sheer lack of

available time to do so. A Victorian pilot study in 2000 found that one-third (36 per cent) of MHT hearings took less than 10 minutes, while nearly two-thirds (60 per cent) took under a quarter of an hour. Only one case exceeded 30 minutes, and that took just 38 minutes (Pearson 2004, 176; Swain 2000, 83). While US court committals are also brief for both adults and juveniles, becoming shorter (and less adversarial) as hospitalisation increases (Perlin 2000, 90–91), MHT hearings observed in Perkins's British study averaged 75 minutes each (Perkins 2003a, 53). Hearings in the Cambridge health area in 2003 were longer still, averaging 160 minutes (ranging from a minimum of 55 minutes to a maximum of four hours and 45 minutes: Dibben, Wong and Hunt 2005, 301). And Lesser reported that hearings 'routinely run in excess of two hours' in England, Scotland and the province of Ontario, Canada (Lesser 2007, 38).

Longer hearing times carry the potential to better realise the legal and social goals of review. More time to review files and information prior to hearings could be equally as important. And *after* hearings, more time for thorough reflection on (and record-keeping about) matters needing to be kept in mind for subsequent hearings may improve the quality of *future* decision-making. In short, realisation of human rights standards in MHTs requires not only multidisciplinary decision-making and the 'prompt' hearings canvassed above, but hearings of adequate *duration* in which to address the core health domains at issue in such hearings. However, long hearings are at present not always possible: a multi-member multidisciplinary panel certainly stands a better chance of coming to grips with the complex issues at play during an MHT hearing of 10 to 30 minutes than does a single member panel.

The need for multidisciplinary panels to achieve independent, competent and fair adjudication

Legal accountability for deprivation of personal liberty is not negotiable under international human rights instruments, or domestic human rights Charters, even if discharge rates by MHTs are low (averaging around 5 per cent in Victoria in 2003, as in Britain: Grundell 2005, 73; Peay 1989, 178), and whatever the cost-efficiency objections (Vine 2007). While low discharge rates partially reflect the fact that only the 'sickest' of the very seriously mentally ill are admitted, other considerations are in fact more pertinent to the value or otherwise of MHT decision-making.

Research shows that looming hearings 'focus' the thinking of clinicians, prompting more genuine consideration of whether compulsory treatment is warranted; of the advantage of less restrictive alternatives; and of the best way of meeting a client's needs (Grundell 2005, 82). Moreover, whether or not under the thrall of human rights rulings shifting the onus onto clinicians to justify continued detention, 2003 statistics

from the Cambridge health region in Britain found much higher discharge rates, with 13 of 55 patients receiving hearings being discharged, while 20 were 're-graded' (moved to voluntary status) *prior* to hearing (Bindman, Maingay and Szmukler 2003).[10]

So the adjudicative body determining whether compulsory treatment is warranted must be both independent and *capable* of bringing an informed mind to the legal as well as the otherwise largely *medical* case for and against continued detention. That is the rationale for retaining legal members on the MHT. However, just as it might be argued that lawyers are dispensable in favour of, say, a medical member sitting alone, questions are raised about the need for anyone *apart* from the lawyer.

Apart from ensuring legal accountability for deprivation of liberty, the tribunal's *main function* (and the space or culture within which it operates) is a *health* context. That is its legislative mandate, and with adequate time, membership, and a decent level of resourcing of the service system, multi-member tribunals provide important value-adding through building therapeutic relationships and overall service outcomes — a 'shadow of law' outcome that would be greatly diminished without the presence of medical members (along with access to a second medical opinion).

Moreover, members from the third category — 'other suitably qualified' members — further broaden the issues and perspectives brought to bear at review hearings. While unable to make deep contributions to strictly legal or medical issues, they bring to the panel their unique individual expertise and background; their knowledge of formal and informal services and supports in the community; and their understanding of the lived experience of mental health service delivery (Adler 1999, 618). They bring a wider view of the balance between treatment needs and the impact of involuntary detention on employment, reputation, domestic lives and responsibilities — such as who looks after animals and collects the mail or pays the bills.

In England, the Leggatt review (2001) recognised the valuable role of non-legal and lay members of tribunals generally. It highlighted the many submissions supporting retention of non-lawyers, including their role in connecting tribunals to the communities they serve; in broadening the experience brought to bear on a decision, particularly in relation to issues of fact; and as 'unqualified members' in helping

10 Sixteen withdrew their applications and six were adjourned. The fate of the other 42 appeals not listed for hearing is unstated.

some users deal with the stress of appearing before a tribunal (Leggatt 2001, 141). Swain's Victorian study likewise found that community members were valued for their *individual contributions* to the review process, rather than skills and experience from any particular unified disciplinary category, and that they were particularly skilled in communicating with participants in tense or complicated circumstances (Swain 2000).

In other words, the inclusion of medical and community members allows tribunals to more fully engage with both the *health* and the *social* context in which legal decisions to discharge or continue involuntary detention are necessarily embedded. The Victorian Consultative Council on Review of Mental Health Legislation in the 1980s recognised this in recommending a multidisciplinary board whose members would serve in a part-time capacity, '*so that they may remain in touch with their professional and community interests*' (Consultative Council 1981, 158, emphasis added). The omission of either of these membership categories surely impoverishes MHTs — the *substantive* content of reviews suffers from a lack of medical and broader clinical expertise; knowledge of different treatment and support options in hospitals and the community; and experience of the daily reality of mental health service delivery. In addition, the *capacity* of single-member tribunals to engage with applicants is likely to suffer, as they struggle to combine listening to patients, running hearings, soliciting and assessing information, and making final adjudications.

Such a multidisciplinary approach is consistent with the UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care 1991, applying the more general human rights set out in international human rights instruments to the mental health context. Principle 17 provides for a review body that must be a judicial or other independent and impartial body established and regulated by domestic law. The Principle states 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 this may be interpreted as requiring that the tribunal includes a medical member (Davidson, McCallion and Potter 2003, 38).

Finally, although not part of the Victorian and ACT Charters as such, the World Health Organization notes that, given the legal and health considerations that these bodies must consider:

> … it is probably advisable that, at the least, an experienced legal and an experienced health professional be appointed. In addition, at least one 'non-professional' person may need to be represented to reflect a 'community' perspective'. [WHO 2005, 69.]

These observations might carry interpretive weight in any 'fair hearing' challenge. Irrespective, it is argued that Parliament and public decision-makers, including MHTs when deciding how to constitute panels in each hearing, should give weight to these observations in acting under or undertaking reform of mental health laws. Such an approach would be truly consistent with the spirit of the Victorian Charter and its aim to promote gradual realisation of rights through dialogue. However, there is a case for fine-tuning the role of community members, which may be somewhat ill-defined as found both in the UK (Perkins 2003a, 31) and in Swain's Victorian study (Swain 2000). Their valuable knowledge, skills and life experience could be better utilised by properly synthesising their broader understanding of psychosocial factors into tribunal decision-making, consistent with the WHO expectation.

Neither the medical nor the community member is a luxury or indulgence, then; rather, both are central to the proper discharge of the jurisdiction. They provide the medical 'translation' of the boundaries between lawful and unlawful detention, and offer access to the essential 'socio-medical context' in which it must be read. Panels of three members, with complementary qualifications and experience, working collaboratively, also correct for deficits of one-member tribunal panels. These deficits are incapable of remedy through provision of better medical or social reports, or by external advocacy alone (currently running at 8 per cent in Victoria: MHRB Vic 2006, 31). Critically important though advocacy is on *other* grounds — such as in protecting a client's right to participate in decision-making about treatment and care planning (Pearson 2004, 177) and in giving voice to the perspectives and interests of the person detained or facilitating therapeutic and other outcomes (Beaupert 2007; Coats 2004; Diesfeld and McKenna 2006; 2007) — representation cannot compensate for MHT panels which are too small or have too little time to undertake their work.

VI. Conclusion

Mental health tribunals undertake vital roles in assessing (at least) three sets of legally relevant considerations when determining whether a person requires compulsory treatment for a mental illness. It is a challenging task to factor into decision-making the combination of fundamental civil rights, health and treatment needs and social and lived realities (Carney 2005; Peay 1982; Richardson 2003; Wallach 2000). However, this enterprise does not occur in isolation: government choices about the design (or funding) of mental health services can transform the mental health review experience for patients, clinicians and other stakeholders (Grundell 2005), notwithstanding that the structure and processes of mental health tribunals impact greatly on human rights protection.

This article has argued that the human rights recognised in Victorian and ACT human rights legislation most likely to impact on the work of mental health tribunals and mental health legislation are the freedom from arbitrary deprivation of liberty and the right to a fair hearing, as has occurred in overseas jurisdictions. Our central point has been that genuinely interdisciplinary, multi-member mental health tribunals are essential: first, on the basis that they are necessary to effectively protect these important human rights; and second, on functional grounds in that they engage the underlying 'health' essence of hearings. This second aspect of multidisciplinary decision-making by mental health tribunals is itself capable of being portrayed as realisation of the *social* right to health. Ideally, mental health tribunals should be better resourced to enable them to devote adequate time to hearings, in order to confidently honour international and domestic human rights obligations for prompt and fair hearings. They should be retained in this form even if not found to be technically 'inconsistent' or 'incompatible' with Charter rights, however, since the *quality* of multi-member decision-making, hearing processes and information handling under such circumstances is, on balance, still superior to that of a single member sitting alone.

When it comes to discretions to allow panels of fewer than three members, for example, it is argued that three-member multidisciplinary panels should be preferred and that incomplete panels should be used sparingly. Ultimately, the complex range of factors that enhance the quality of mental health tribunal decision-making discussed above underlines the importance of a genuine commitment by public decision-makers to reform and implement laws in a fashion consistent with 'human rights', rather than simply defaulting to a lowest common denominator model of narrowly defined civil rights. ●

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