Procedural fairness in mental health review tribunals: the views of patient advocates

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Mental health review tribunals face the difficult task of balancing an obligation to be efficient and accessible against the obligation to provide procedural fairness. We conducted focus groups with lawyers and advocates who support people with matters before the Queensland Mental Health Review Tribunal to ascertain their views on issues relating to procedural fairness in this particular forum. Consistent with similar studies in other jurisdictions, our participants expressed concerns about how well informed their clients were about the proceedings, the probative value of the evidence relied upon and the extent to which medical evidence is effectively challenged. We analyse the concerns raised by our participants in light of the limited Australian case law on procedural fairness in mental health review tribunals.

Keywords: mental health; mental health review tribunal; procedural fairness; tribunal.

Introduction

Mental health review tribunals have been established in most states and territories in Australia.¹ These tribunals are required to make legal decisions about involuntary treatment for people with mental illnesses.² Striking the right balance between fairness on one hand, and accessibility on the other, has been noted as an ongoing challenge for Australian tribunals.³ Arguably, an appropriate balance is particularly difficult to achieve, but assumes special importance in the case of mental health review tribunals.

The justifications for resolving matters in tribunals, rather than courts, are efficiency and accessibility.⁴ The assumption is that by moving away from formal court rules and procedures to a less formal set of procedures, matters can be finalised more quickly, and unrepresented individuals can more meaningfully participate in proceedings.

Mental health review tribunals are required to decide whether or not an individual will be subject to involuntary medical treatment, and possibly, whether or not that individual must also be detained. Clearly, these are very weighty decisions.⁵ In fact, the tribunal's forensic order jurisdiction could be considered to form part of the criminal justice system.⁶ In these circumstances, it is expected that the decision-maker will act with utmost care, rigour and impartiality.⁷ On the other hand, due to the challenges faced by people with mental illnesses, the goals of accessibility and informality may be more important in mental health proceedings.⁸

The aim of this research was to investigate the manner in which the Queensland Mental Health Review Tribunal (QMHRT) makes decisions in the context of these competing objectives. In this paper, we assess current QMHRT practices against the rules of

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‘procedural fairness’ that have developed in the common law.⁹ There are three reasons for this focus. Firstly, procedural fairness is known to play a central role in the public’s respect for and compliance with the law.¹⁰ In the area of mental health law, studies have shown that the perceived fairness of procedure has a significant impact on how those compulsorily detained and treated for mental illness accept the decisions made about them and engage with treatment.¹¹ Secondly, adherence to the rules of procedural fairness may be inherently challenging for tribunals that are required to practice less formal decision-making,¹² and studies in various jurisdictions have uncovered concerns in relation to procedural fairness in mental health tribunals.¹³ Thirdly, the common-law rules of procedural fairness represent an established set of legal obligations that rest on the QMHRT.¹⁴ There is a significant body of literature that critically assesses the way in which decisions about involuntary treatment for mental illness are made through different lenses such as therapeutic jurisprudence,¹⁵ discrimination¹⁶ or human rights.¹⁷ But to our knowledge, previous studies in Australia have not analysed the decision-making of mental health tribunals specifically in relation to the current legal requirements imposed by the rules of procedural fairness.¹⁸

This article reports on the results of empirical research involving focus groups with lawyers and advocates who support people with mental health difficulties appearing before the QMHRT. We begin by providing some context, outlining the relevant provisions of the *Mental Health Act 2016* (Qld). We then turn to the study’s methodology and results, before analysing our findings in light of the literature and case law on procedural fairness.

The Queensland Mental Health Review Tribunal and the *Mental Health Act 2016* (Qld)

Like most tribunals in Australia, the QMHRT occupies a contested legal and administrative

space between the executive and judicial arms of government.¹⁹ The QMHRT is required to act independently when exercising its discretion,²⁰ but it receives its funding from Queensland Health (not the Department of Justice and Attorney-General).²¹ Its members are appointed for fixed terms; the president for five-year terms, other members (medical, legal and community) for three-year terms.²² In this way, the QMHRT is distinguishable from a court, as the separation of the judicial and executive arms of government is achieved, in part, by judges having tenure.²³ Yet, the QMHRT must determine whether people will be given medical treatment, and possibly also detained, against their will.²⁴ Therefore, the QMHRT, while formally a part of the executive arm of government, exercises ‘judicial power’, as it makes ‘binding declarations of rights in the course of adjudicating disputes about rights and obligations as a result of the operation of law upon events or conduct that have or has occurred’.²⁵

Of course, many other state tribunals with fixed-term appointments for its members similarly exercise judicial power. Most prominently, this includes the ‘super tribunals’, like the Victorian Civil and Administrative Tribunal (VCAT), which now operate in most states and territories in Australia.²⁶ Importantly, appeals of QMHRT decisions to the Mental Health Court are by way of rehearing,²⁷ and there is nothing in the *Act* to limit the grounds of appeal.²⁸

The current *Mental Health Act 2016* (Qld) came into effect in March 2017 and largely maintained the composition and procedure of the QMHRT as it had existed under the previous *Mental Health Act 2000* (Qld).²⁹ One change brought in by the *2016 Act* was an expansion in the role for representation in QMHRT hearings,³⁰ including a right to have a lawyer appointed in fitness for trial reviews and forensic order reviews in which the Attorney-General has elected to appear, as well as cases involving minors and where the tribunal considers it would be in the best

interests of the person.³¹ The *Act* requires legal representation to be provided in these circumstances at no cost to the person,³² and it also allows for the person to be accompanied by a ‘nominated support person’, who could be a family member, carer or other nominated person.³³

In most cases, the QMHRT makes decisions about involuntary treatment for mental illness by reviewing treatment authorities. The QMHRT’s other main task is to review forensic orders,³⁴ that is, it must determine whether to confirm or revoke the forensic order,³⁵ and if the order is to be continued, it must determine whether the order will be an inpatient or community treatment order.³⁶ In the 2018–2019 financial year, of the 20,220 matters that were ‘opened’ at the tribunal, 16,352 were treatment authority reviews and 1777 were forensic order reviews, so these types of matters are those most commonly heard by the QMHRT.³⁷

What do the rules of procedural fairness require in this context?

The *Mental Health Act 2016* (Qld) empowers the QMHRT ‘to inform itself on a matter in any way it considers appropriate’.³⁸ The *Act* states that the Tribunal is not bound by the rules of evidence³⁹ and requires the Tribunal to act ‘as quickly, and with as little formality and technicality, as is consistent with a fair and proper consideration of the matters before the tribunal’.⁴⁰ However, the *Act* also requires the QMHRT to ‘act fairly and according to the substantial merits of the case’⁴¹ and to ‘observe the rules of natural justice’.⁴² In any case, it is well established that unless expressly excluded, administrative decisions that affect a person’s rights or interests must comply with the rules of procedural fairness.⁴³ The concurrent requirements to be efficient and informal on one hand, and to observe the rules of procedural fairness (or ‘natural justice’) on the other, similarly apply to many other tribunals in Australia, including the state ‘super tribunals’ like VCAT.⁴⁴

What procedural fairness requires of a decision-maker varies according to the specific circumstances of the decision being made.⁴⁵ For the QMHRT, some procedural instructions are set out in the *Act*; any further guidance must be taken from the case law on procedural fairness. Clearly, tribunals like the QMHRT, which are required to be as efficient and informal as possible, would not be expected to follow the rules of formality and procedure that apply to courts.⁴⁶ The question is: how informal and flexible can such tribunals be without offending their requirement to observe the rules of procedural fairness?

Case law provides some guidance on this; however, as will be seen, case law relating specifically to Australian mental health review tribunals is extremely sparse.

In a general sense, the requirement of procedural fairness comprises two rules, the hearing rule and the bias rule.⁴⁷ The hearing rule itself comprises a number of individual considerations, for example, sufficient prior notice of a determination is a general principle of procedural fairness that affects all administrative decision-making, including tribunal decisions.⁴⁸ Consistent with this, the *Mental Health Act 2016* (Qld) requires a patient to be given seven days’ notice of a hearing,⁴⁹ and clinical reports must also be made available to clients at least seven days before the hearing.⁵⁰ The hearing rule further requires that the person who is the subject of the proceedings is able to respond to information from which a fact finder could make an adverse inference and that any information provided is communicated in such a way that the person can understand.⁵¹ This requirement is reflected in the provisions of the *Mental Health Act 2016* (Qld). One of the principles of the *Act* is that a person ‘is to be encouraged to take part in making decisions affecting the person’s life, especially decisions about treatment and care’.⁵² Another is that a person is to be ‘provided with necessary support and information to enable the person to exercise rights’ under the *Act*.⁵³ The provisions relating to

notice requirements, and the availability of legal representation, could also be seen as supporting this principle.

The second component of the requirement for procedural fairness is the bias rule. Bias may be actual or apprehended, although cases of actual bias are more difficult to prove and are less common.⁵⁴ The accepted test for apprehended bias in Australian law is:

whether a fair-minded lay observer might reasonably apprehend that the judge might not bring an impartial and unprejudiced mind to the resolution of the question the judge is required to decide.⁵⁵

In the context of mental health review tribunals, bias may take the form of prejudice if a decision-maker is ‘so committed to a conclusion already formed as to be incapable of alteration, whatever evidence or arguments may be presented’.⁵⁶ However, it is important to note that conduct by a judge in adversarial litigation that would give rise to a reasonable apprehension of bias might be considered acceptable if engaged in by a tribunal.⁵⁷ Indeed, procedural fairness may oblige a tribunal with inquisitorial powers faced with an unrepresented party to take an active role in the hearing; what is required is a balance between the exercise of its inquisitorial function and fairness of process.⁵⁸

We discussed issues relating to both components of procedural fairness – the hearing rule and the bias rule – with our focus group participants.

The study

Methodology

This project provides some empirical evidence of the operation of the QMHRT under the new regime of the *Mental Health Act 2016* (Qld). To examine how the QMHRT fulfils its obligation to comply with the rules of procedural fairness, whilst also ensuring that its processes are informal and accessible, we convened a series of focus groups with lawyers and

advocates who support people appearing before the QMHRT.⁵⁹ We emailed all relevant organisations – legal centres, non-government organisations and statutory authorities – to determine whether or not they would be willing to participate in a group interview at their premises. All but one of the organisations we contacted indicated their willingness to participate.⁶⁰ We then attended their premises at an agreed time and conducted a group interview.

The focus group interviews were semi-structured in nature, and the same prompt questions were used for each group. The questions asked participants to reflect on the following themes:

- How informed their clients seemed to be about the nature of the hearing, and how prepared they were for the hearing;
- Whether or not their clients were able to meaningfully participate in the hearing;
- The kind of evidence relied upon and the probative value of that evidence;
- The nature of any oral submissions made by those present and the nature of any questions posed by tribunal members during proceedings;
- Whether or not the QMHRT is sufficiently accountable and transparent in respect of its processes and determinations and the role of lawyers and advocates in this.

Focus group methodology was appropriate for this project because this research was exploratory in nature. Our aim was to generate new qualitative data and to allow for unexpected findings by facilitating a fluid discussion of relevant issues amongst a relatively homogenous group of professionals.⁶¹ Our goal was to ‘elicit people’s understandings, opinions and views’ on a topic that our participants all shared expertise in without imposing an unreasonable burden on their limited resources.⁶²

We acknowledge that there are some limitations associated with using a focus group methodology. The problem with interviewing a homogenous group of professionals is that the perspectives of only one stakeholder group are represented – other stakeholders may well hold very different views. There is no real way of corroborating the data provided, confirming the accuracy of the stories that are shared or eliminating bias.⁶³ Further, the group dynamic may result in the silencing of individual voices of dissent.⁶⁴ Having said this, focus group research is useful, as interactions between participants can themselves generate data because through exchange, participants are able to engage in ‘collective sense-making’ of their shared experiences.⁶⁵ Importantly, the opinions of our participants were not uniform, and we have been careful to note any points of dissent and subjects of disagreement between participants in the results section below.

All of the focus groups were audio recorded and transcribed, and all participants signed a consent form agreeing to this. We obtained ethical clearance for this study from two university human research ethics committees.⁶⁶

Participants

Nine focus groups were held, with a total of 36 participants. Participants were lawyers, student lawyers, social workers and staff of relevant statutory agencies. Of the 36 participants, 19 were solicitors or barristers and 17 worked for advocacy organisations, either in statutory agencies or non-government organisations. Each organisation and individual agreed to participate on the basis that they would remain anonymous and their employer’s identity would remain confidential. Twenty-one participants were female and 15 were male. Most of the participants referred to the people with mental illness whom they work with as ‘clients’, rather than ‘patients’, so that is how we have described them in this paper.

This small empirical study obtained the perspectives of those who work alongside, and

advocate for, people with mental illness; employees of the QMHRT, including tribunal members, were not invited to participate, nor were employees of mental health services, psychiatrists or treatment team members. Ascertaining the views of these other stakeholders, and the views of clients themselves, is an important avenue for future research. It must be noted that most of our participants ($n = 20$) were trained as lawyers, and the perspectives of other professional groups and individuals may be different, particularly as regards the importance of procedural fairness and the role that lawyers play, or should play, in tribunal proceedings.⁶⁷

Data analysis

Once all of the focus groups had been completed and transcribed, both authors undertook content analysis and identified themes for coding.⁶⁸ The themes identified by each author were compared with one another, and a common set of themes was agreed upon and codes were developed. The transcripts were then analysed by the authors again, using these thematic codes. Manual coding was undertaken, whereby each time a participant mentioned a code, this was marked in the margin of the transcript, and a descriptive count of codes was then taken across the groups. The focus groups were also entered into NVIVO so that recurrent terminology could be identified and counted. The results of the qualitative analyses are presented in the following section of the paper.

Results

Access to information about tribunal hearings and processes

As noted above, it is a legislative requirement that individuals who are the subject of QMHRT proceedings be provided with written notice of the hearing.⁶⁹ However, some of our participants said that clients often do not receive these notices, perhaps because they have changed address, or have recently been

an inpatient, or because they live in regional areas where ordinary mail is slow.

Participants in all nine focus groups said that even when clients do receive written notice of the hearing, they often did not understand the purpose of the hearing or the nature of the tribunal's processes unless they had attended a hearing before. Participants said:

They certainly don't understand [the hearing notice] if they do [receive it]. A lot of the people we work with have dual diagnosis. So they don't have the support to really understand that document. (FG3)

They're informed of it [the hearing], but they often don't understand it and they're very rarely prepared. (FG2)

Participant 2: When you first engage with clients they often have no idea what's going on, some of them don't even know that they have a hearing coming up, things like that. Which is obviously very concerning.

Participant 3: And I've also found the same – similar thing. Like, clients don't even know the process of the tribunal hearing and they just are a bit clueless [about] what's happening. (FG4)

Some participants believed that in some cases neither the QMHRT nor the client's treating team provided them with sufficient notice and information about the hearing:

The requirement is that they have the report discussed with them, and quite often it's not explained what the actual purpose [of the hearing] is. They'll turn up, and quite often they'll decline to attend a hearing because they don't understand what it's about, and when they do attend, they don't really know what they seem to be there for. (FG9)

I don't think they would often understand the processes. They've never seen their treatment plan, most of them, so I don't think they really know enough to understand what's going on. It's a very foreign process unless you've been through them all the time. (FG3)

Others thought that whilst clients may have the process explained to them, this was not always done in language they were able to understand:

I also think that the people doing the explaining quite often don't use language that's freely accessible to the clients. So they might put it in those clinical terms what the hearing is about, and what they're going to discuss, but you're dealing with people that might have an intellectual, or cognitive impairment that don't have the availability for that language group to their own understanding. So it's difficult for them to understand what's being explained to them, as well as often not being told until the day before. (FG9)

Participants agreed that their clients' failure to understand the nature and purpose of proceedings impacted upon their ability to participate and be heard:

If they don't understand the material, if they don't really understand why they're there, how can they put their best foot forward and provide an adequate explanation? I don't know how they can. (FG8)

Participation in tribunal proceedings

Participants described a number of barriers to their clients' participation in tribunal proceedings. Some of these barriers related to their clients' psychiatric and other impairments, whilst others stemmed from the nature of the proceedings.

Participants said that their clients often found hearings to be 'intimidating' and 'stressful', indeed some said their clients were so 'nervous' and 'fearful' that they were 'physically sick' or unable to remain in the room. In addition to this, for many clients, their 'clinical presentation could interfere with how much they can actually participate' (FG1, agreed in FG5). For example, participants said that the nature of their client's diagnosis, or

the fact that they were heavily medicated, sometimes meant that they were too unwell to meaningfully participate.

The hearing venue also affected clients' ability to participate in proceedings. In particular, where proceedings were held at the hospital, clients were often reluctant to attend or speak up in front of their treating team:

Some of the clients we've had have found it very confronting to go back into a mental health ward that's locked. ... We've had some who've really struggled just to go back in to have a hearing. (FG4)

How comfortable is the patient actually expressing themselves when you're in front of, not only the strangers, but the treating team that's in charge of what happens to you every single day? ... [T]hey are a figure of authority to the patient ... most people from my experience are usually reluctant to speak out against authority, especially if that authority has direct control over your life. (FG7)

Participants explained that holding hearings at the hospital also gave clients the impression that the tribunal was not independent because 'the whole environment is controlled by the hospital' (FG3):

[The hearing] is often within the treating facility. The whole feeling is that this is just a part of the institutional – it's not so much of an independent review. (FG6)

The hospital has all this power over them so it's difficult for them to speak freely. (FG3)

Participants were also critical of proceedings being convened via videolink or teleconference. Participants who had been involved in proceedings over video or telephone said that the technology often failed, they could not hear everything that was being said and they did not know who was speaking at any given time. They also said that despite all of these problems, hearings often proceeded, even in

circumstances where it was impossible for the lawyer and client to follow what was happening. Whilst most participants said they preferred a videolink to a telephone hearing, there was general agreement that both were 'unsatisfactory' (FG2), particularly considering the nature of the client group. As one participant noted:

Clients sometimes don't do well with hearing voices at the other end of the phone. Neither do we. (FG9)

Evidence before the tribunal

Participants in all focus groups were critical of the quality and accuracy of the evidence put before the tribunal. Participants emphasised that the clinical reports, which are 'the main evidence before the tribunal', generally contained inaccuracies, were out of date and mostly comprised 'historic information'. They said that these reports were essentially 'a collection of anecdotal evidence' and unsubstantiated comments with 'little actual evidence':

It will often be a blanket statement of, there's a risk to the community, therefore the order should continue. Without an actual interrogation, or identification of, well, what's the actual risk? What's the assessment of the risk? What are you relying on to say there's a risk? (FG9)

They might say something that's not backed up, you know, it's just a statement that there is an imminent risk without anything to substantiate it and that's enough. (FG1)

In six of the focus groups, clinical reports were described as a 'cut and paste' of previous reports containing old and inaccurate 'allegations'. Participants in other groups agreed with this, but used different terminology, describing the reports as 'a mess' (FG8), 'all over the place' (FG8), 'a dog's breakfast' (FG9) and 'piecemealed together' (FG5). Participants said that clients often

became distressed at the inaccuracies contained in the reports, yet despite this, the reports were rarely corrected. Participants agreed that the reports often did not accurately reflect the person's current mental health status and mainly focused on past assessments of risk, often dating back many years:

They're not really a fresh look at the person as they are now. (FG3)

It's information that's 10 or 15 years old, and it's presented in a way that makes it seem it's still current and relevant. (FG9)

Participant 1: They only get looked at for their medical history, their past, rather than what's going forward. Which is not great.

Participant 3: Actually, that's an interesting point. They do tend to concentrate on things that are never going to change.

Participant 2: Static factors. (FG2)

Participants further explained that lawyers were limited in their capacity to orally test the evidence contained in the reports because the treating psychiatrist does not always appear before the tribunal:

Quite often you'll find that the treating psychiatrist doesn't work on a Thursday and so they're proxied by someone who the only document that they've got is that clinical report and they can't speak to it well enough. [Another team member] might be sitting there going, 'yes, well, I haven't seen the person in four months, so I don't really know what their status quo is'. So there's a real lack of available concrete information being presented to the tribunal. (FG9)

Tribunal procedures related to questioning and hearing oral submissions

Even if someone from the treatment team with knowledge of the client did appear, participants said that lawyers were not permitted to cross-examine, or ask questions of, health

service staff. Instead, they were required to direct any questions to the tribunal members:

It's an inquisitorial jurisdiction, but with a limit [on] how you can be inquisitorial. And we won't allow you to question medical treating teams, because it's not about interrogating them, but how do you identify whether a treatment is appropriate if you aren't allowed to question the treatment? (FG8)

It's inquisitorial, therefore any questions you have are directed to the tribunal. You're not actually allowed to ask questions of any parties ... it doesn't have to be aggressive, it doesn't have to be adversarial. But it indicates to people [that] you're not allowed to question, you're not allowed to ask about either the Attorney-General's position, or the treating team's position. And the MHRT supports that view. (FG9)

Whilst participants generally agreed that a level of informality of proceedings was appropriate and important for their clients, many of the participants felt that relaxing the rules of evidence put their clients at a distinct disadvantage because 'opinion' was being confused with 'evidence':

It's just basically whoever happens to be sitting at the table can make a statement about the person and it's considered. (FG3)

If the doctor wants it, that's evidence. ... Really what they're doing is they're expressing a personal medical opinion without actually putting the medical evidence for the treatment before the tribunal. (FG7)

Participants in two of the focus groups raised concerns regarding the questioning of their clients by tribunal members. They said that the questions asked of clients were sometimes inappropriate, because they were too 'personal', expressed in a 'hostile' manner or were 'very leading':

Certain questions get asked in a very leading manner, and there's no real

mechanism for us as their advocates to oppose those questions being asked in the manner in which they're asked. And those leading questions take the person to an inevitable conclusion, which is the self-serving conclusion generally to confirm the order, or confirm the treatment authority. (FG5)

Participant 5: They've really loaded the questions sometimes.

Participant 3: I agree. ... They'll lead the answer. 'As was said, you've been taking this medication for six months, and you feel a lot better now, your behaviour is a lot calmer'. And the client quite often will just agree with that. (FG9)

Considering the serious consequences of the decisions being made, participants in all groups suggested that a better balance could be struck between formality and flexibility:

[The tribunal] should be picking up on, well, inconsistencies. They should be picking up on if the evidence is weak. ... That's not natural justice, when the evidence before the tribunal is clearly not robust, not supported by anything objective, and it's only supported by an opinion without any kind of justification behind it. (FG7)

Transparency, accountability and the role of lawyers

Participants in all focus groups said that most often, the tribunal simply approved the recommendation of the treating psychiatrist, and that 'they really don't provide an independent check' or a 'proper process'. In four of the groups, participants described the decisions of the tribunal as a mere 'rubber-stamp' of the medical team's determinations. Participants used many other phrases to express the same view, including: 'psychiatrists rule the day' (FG2, S2); 'whatever the psychiatrists says goes' (FG2, S3); 'doctors are the law' (FG3, S4); 'the treating team's evidence is gold every time' (FG5); 'whatever the medical staff say, goes/It's their tribunal' (FG7); 'most of it is just, trust me, I'm a doctor' (FG7); 'the

clinical team's position is taken first and foremost' (FG9). In four of the focus groups, the phrase 'tick and flick' was used to describe the tribunal's decision-making process – the consensus was that there was generally no substantive engagement with the relevant legislative criteria and no independent discussion or critique of the psychiatrists' recommendations. In two groups, the tribunal was described as 'biased' towards the doctors. Participants were concerned that even when the contents of the clinical report were questionable, tribunal members did not always test the evidence presented to them:

The majority of the actual hearings are just, you had that behaviour once, you're a high risk, so everything else is secondary. (FG8)

It's like someone else told you something and now it's taken as law or it's taken as fact. ... And it shows up in the clinical report, it's then taken as, yes, that's actually what happened. (FG4)

The clinical report occupies the field and there's no contest to its conclusions. (FG6)

It's basically like, we've come to that hearing on the basis that this is the gospel, and whatever is said in this report is basically the whole truth. (FG9)

Participants agreed that the only way to challenge the evidence of the treating team was to obtain an independent report, however this was generally not possible for their clients because they had limited means:

You needed to challenge the tribunal's evidence and the treating team's evidence, you need your own independent evidence. And psychiatric reports start at \$2,000, right? And our clients personally have very little money. (FG2)

Indeed, participants in seven of the focus groups expressed the view that lawyers were 'useless' in MHRT hearings because the outcome of proceedings was predetermined.

Many of the lawyers said that they felt that appearing before the tribunal was a 'waste of my time' because they were unable to influence the result. They made comments such as:

What's the point in having an MHRT hearing? ... I don't want to waste my time as a solicitor being allocated to a task like that if I can't fight it. There's no point. (FG2)

It's sort of like they've already formed an opinion on a lot of these criteria before they even get to the hearing ... it just seems like you're already playing from behind for a lot of these clients. (FG4, S5)

The reason I stopped doing tribunal hearings was because I felt the outcome was predetermined and a waste of my time. (FG4, S4)

Even when people are legally represented, it's like just completely pointless. I don't even think that they really can get to say anything, and if they do, again it's also completely discarded. (FG9)

Participants in all groups agreed that the tribunal was 'cautious' in its decision-making, often basing its decisions on the 'worst' or 'most conservative' report. The phrase 'risk-averse' was used to describe the tribunal in seven of the focus groups. One participant said in respect of forensic order review hearings:

I feel like you'll get a range of reports from a range of different sources but the tribunal disproportionately gives weight to the report which is most restrictive of your client's rights. (FG1)

Participants explained that, as a result, orders were confirmed or renewed in almost all cases, and that 'not many clients ever get out' of the order being made.

A written statement of reasons can be requested, but it can take up to 21 days to receive,⁷⁰ and participants described them as inadequate. At best, participants described the written reasons as 'just a summary', 'lacking

in substance', 'instinctively selective', which 'often [don't] have everything that was said' and are 'not really a completely accurate record':

We often find that whatever they've written in the statement of reasons doesn't paint a full picture of what we've noticed or what the clients have felt happened. (FG4)

Even when you do request a reason, I find they're often lacking in substance. That it will be a throwaway line saying, 'we've seen the evidence, and we're satisfied'. (FG8)

At worst, participants said that the written reasons can be misleading and even deliberately self-serving in some cases:

Sometimes if you request a statement of reasons and you need to get an appeal notice in quickly, the statement of reasons will come back addressing your appeal grounds that you've put in ... I had one statement of reasons that came back with just blatantly saying things that I know I actually didn't say. They weren't in my notes and I checked with [another person in attendance]. But you've got limited opportunity to be able to really raise that dispute because there's no common record. (FG4)

Participant 1: There's plenty of things in statements of reasons that I've seen where, as far as I saw, that's not what was said, or that's not what happened. But you can't challenge that because –

Participant 2: Because there's no record. (FG7)

Thus, participants said that the lack of transparency of the tribunal was compounded by the fact that no record of proceedings is taken. At the time of our study, there was no audio recording, no transcript of proceedings was generated and no statements of reasons were published: 'it's all off the record, basically' (FG5). Participants in all groups discussed the consequences of there being no

comprehensive statement of reasons and no record of proceedings, in terms of consistency and accountability:

It's really hard to hold them accountable in certain situations because there'll be no record of what we'll find to be an error in judgement or whatever it may be. There's no record of it, so they're controlling what the record is. (FG4)

Not only is there no recording, but they never publish their decisions. ... If you don't have recordings or publications, there's no consistency in decisions. (FG7)

More specifically, many participants raised the fact that since there was no record of proceedings, there are 'no precedents' or at least none that lawyers had access to. This, they said, made it difficult for them to effectively advocate for their clients:

The legal representatives aren't privy to all the [Mental Health Court] precedents that are available. So the tribunal, the panel members, will rely on decisions that have been handed down in the Mental Health Court but we don't have access to or even know about those judgements. So we're unaware as legal representatives that there is precedent law available and that the tribunal are relying on. And to make it even worse, the Attorney General representatives usually are privy to that. So it's not a fair playing field for all concerned. ... In another forum, you would expect as a lawyer to be able to say, 'well, I haven't been told about that case, or I don't have access to that case, and that's unfair, therefore you shouldn't rely on it'. But it's not that kind of forum. (FG1)

Participants agreed that proceedings should be recorded and that a transcript of proceedings should at least exist and be accessible for the purpose of an appeal:

If you do not have a record of what proceeded in the discussion, and you're relying on a statement of reasons that is

provided sometimes weeks after the event, how are you able to clearly articulate where the error is, or what you are appealing against? (FG8)

[The absence of a recording] makes it almost impossible to appeal any decisions. ... How do we know that the people that are making the decisions are making them in a legislative way? What sections of the legislation are the decisions being made under? It all goes hand in hand, really. (FG9)

Two participants raised the concern that if proceedings were recorded, people could 'be more guarded and they won't speak freely' (FG2). However, people who held this view were in the minority. The most commonly expressed view was that recording proceedings would likely improve the quality of the interactions between parties at the hearing because at present people 'can freely say what they want without ramification'. One participant said:

We would get more accountability and hopefully more consistency across the State. And sometimes even if there isn't maybe an error in the decision, sometimes there'll be some really inappropriate things are said. ... If there was a recording, I'd be able to access that and then feed back to the tribunal and say, 'look, I was concerned by this question'. (FG4)

Since these focus groups were performed, the QMHRT conducted a survey among stakeholders on the topic of audio-recording its hearings. Most responses received were in favour of commencing audio-recordings, and the Tribunal has 'agreed in principle' to do so.⁷¹ Also since these focus groups, the QMHRT has commenced publishing a limited number of statements of reasons on its website.⁷²

The vast majority of participants agreed that the QMHRT needed to become more transparent and accountable, particularly given

the vulnerability of the people coming before it, and the gravity of the decisions being made:

It's a tribunal dealing with some of the most vulnerable people in the state, and it has the power to approve things to be done to people that no one else can do. ... And it also authorises the continued detention of people. So with those kinds of powers should come high levels of accountability and transparency. And it's the least accountable and transparent tribunal in the state. (FG7)

It's a gross infringement on human rights to undertake that kind of decision-making that restricts a person's either free movement in the community, or a treatment that essentially is forced upon them, and then not record those decisions. I don't know of any other jurisdiction across Australia who proceeds in that way, who doesn't have that accountability for the decisions that they make for people. (FG9)

Discussion

Since our focus groups were held, the *Human Rights Act 2019* (Qld) has come into effect, and there is potential for this legislation to impact upon the manner in which QMHRT proceedings operate. Whilst there is some scepticism as to the effectiveness of human rights instruments with respect to mental health decision-making,⁷³ the rights to self-determination, freedom from non-consensual medical treatment and personal inviolability were referred to recently by the Victorian Supreme Court in *PBU and NJE v Mental Health Tribunal* when over-turning an approval for electroconvulsive treatment.⁷⁴ The *Human Rights Act 2019* (Qld) includes a right to have one's civil proceedings 'decided by a competent, independent and impartial court or tribunal after a fair and public hearing',⁷⁵ and this would seem to assume particular importance with respect to mental health review tribunal hearings.

However, Justice Emilios Kyrou has said of the equivalent Victorian provision that it is 'unlikely' to 'add materially' to the existing requirements of the rules of natural justice.⁷⁶ Carney et al point out that in the Australian system, the primary vehicle for the protection of rights has been the 'procedural safeguards' that mental health tribunals provide, rather than directly enforceable rights (that may derive from specific rights instruments), like the right to refuse treatment.⁷⁷ It may be that jurisprudence pertaining to human rights legislation and mental health will develop further in the future. Yet at this point, the rules about procedural fairness in mental health review tribunals arguably remain one of the most important legal mechanisms for the protection of the rights of people with mental illnesses.

Chief Justice Robert French has noted that the concept of procedural fairness has informed the common-law system from its inception.⁷⁸ The justifications for imposing this requirement on decision-makers are both instrumental and ethical, promoting decision-making that is better quality and more just.⁷⁹ One specific justification is that it promotes confidence in official decision-making,⁸⁰ a consideration that is arguably heightened in the case of mental health tribunals, which determine whether coercive procedures are to be authorised. Importantly, studies have shown that mental health patients' perceptions of the fairness of tribunal proceedings will affect their response to the coercion that the proceedings may authorise.⁸¹

In this section of the paper, we will examine three of the key themes that emerged from the focus group data on procedural fairness – notice and the provision of information; evidence; and 'rubber-stamping' – in light of the literature and available case law. It is important to note at the outset that very few reported decisions have been handed down that address in detail procedural fairness requirements as they relate to Australian mental health review tribunals. Relevant case law that does exist will be discussed here, as will the applicable literature.

Notice and the provision of information

As noted above, many of our participants said that their clients did not always receive notice of their QMHRT hearing, or were unable to understand the documents that were provided to them. This reflects the experiences of some participants in Carney et al's study on mental health review tribunals in New South Wales, Victoria and the ACT.⁸² One question that case law has yet to make clear is whether and to what extent the procedural fairness requirement of sufficient notice must take into consideration the particular circumstances of an individual who may face communication barriers.

Aronson, Groves and Weeks argue, in the context of persons from non-English speaking backgrounds, that because the purpose of notice is to enable participation, 'the content of the notice must be such as to allow its recipient to participate fully and effectively in whatever manner is found to be appropriate in the circumstances of the particular case'.⁸³ They concede that there is no general rule that notice should be given in the party's first language,⁸⁴ however, they argue that in certain circumstances, a translation may be required, for example, if the decision-maker knows that the applicant does not read English and would not be able to get a translation in time.⁸⁵ Courts have not addressed the question of whether special arrangements for notice must be made for people with communication difficulties associated with mental illness; however, an equivalent argument could be made. If the notice provided by a mental health review tribunal does not allow the party to 'participate fully and effectively' in proceedings, then this may potentially breach the rules of procedural fairness. This will be especially so where, as would normally be the case, the tribunal ought to be aware of the mental health issues that impeded the party's understanding of the notice provided.

Another matter that is not wholly settled by the case law is the extent to which relevant information must be made available to a person in preparation for a hearing. In *EO v*

Mental Health Review Board,⁸⁶ the Western Australian Supreme Court considered a review of a patient's involuntary status by the Western Australian Mental Health Review Board. Like the *Mental Health Act 2016* (Qld), the Western Australian *Mental Health Act 1996* (since repealed) directed the Board to act 'without regard to technicalities and legal forms' and declared that the Board was 'not bound by the rules of evidence'.⁸⁷ In *EO's case*, the appellant had applied to a hospital for access to his medical records. The appellant was only provided documents pertaining to his current admission, not previous admissions; yet the Mental Health Review Board made reference to materials relating to the appellant's previous admissions in its decision. Section 160 of the *Mental Health Act 1996* (WA) gave people in the appellant's position the right to inspect and be given a reproduction of 'any relevant document'. However, it was the hospital's policy to only provide information relevant to the 'current or recent period of detention'.⁸⁸ Templeman J found that this policy was 'a clear breach' of section 160.⁸⁹ Importantly, Templeman J also found that procedural fairness was not afforded to the appellant because he did not have access to 'relevant material'.⁹⁰ This was considered of 'utmost importance' because the operation of the *Act* on the appellant could result in his involuntary detention.⁹¹ On this reasoning, it would seem that procedural fairness requires that parties are provided with all material on which a mental health tribunal may make a decision before a hearing.

Many of our participants were concerned that their clients had not been adequately informed of their rights, and this concern has been raised elsewhere, particularly in relation to patients' right to representation (where relevant) and their right to appeal.⁹² Carney et al express the opinion that the process of informing patients of their legal entitlements may not be implemented in a way that is sensitive to the unique communication needs of individual patients.⁹³ Our participants made similar observations.

Challenging evidence: cross-examination and oral submissions

Certain formal rules of court procedure, such as the rule in *Browne v Dunn*,⁹⁴ do not apply to tribunals that are given the right to inform themselves as they see fit and to act expeditiously.⁹⁵ Yet, wherever a person's rights are affected, the hearing rule requires that the person have 'a fair and adequate opportunity of answering any allegation or charge'.⁹⁶ Therefore, affected persons must have an opportunity to challenge any material upon which a mental health review tribunal bases its decision.⁹⁷ This requirement is closely connected to the right to have access to evidence that is relied upon in decision-making. In *EO v Mental Health Review Board*,⁹⁸ the respondent had argued that failing to provide the appellant with documents pertaining to previous hospital admissions did not amount to procedural unfairness, because the documents did not disclose anything adverse to the appellant. Templeman J explained why this argument failed, stating that:

[It] overlooks the important point: the appellant was denied the opportunity of considering whether there was anything either positive or negative in the relevant materials and was denied the opportunity, which has now of course been lost, of making submissions to the Board in relation to anything which might have been in the notes and, more importantly, of questioning [the psychiatrist who provided evidence] about those matters.⁹⁹

Rees argues that in tribunals exercising 'judicial power' there is a right to cross-examine witnesses called by the other party.¹⁰⁰ However, he also acknowledges that there is no case authority for this as a general proposition, and therefore whether the right exists depends on the circumstances.¹⁰¹ Many of our participants believed that unfairness often resulted from the fact that lawyers and clients were not entitled to challenge the evidence put to the QMHRT by the treatment team through cross-examination.

Some of our participants also felt that it was unfair that witnesses had the benefit of hearing one another's evidence because it allowed for, and facilitated, corroboration. Others said that having an 'informal discussion' with the client at the start of proceedings, before hearing the medical evidence, meant that the QMHRT deprived the person of the chance to effectively respond to the evidence of the treatment team.

The order in which evidence is heard, and the possibility that this could result in unfairness was addressed in *MH6 v Mental Health Review Board & Anor*.¹⁰² In that case, the Victorian Court of Appeal considered the question of procedural fairness regarding a VCAT order for involuntary treatment of the applicant. The VCAT hearing itself resulted from an application to review a decision of the Mental Health Review Board; VCAT, like the QMHRT, was not bound by the rules of evidence but was required to observe the rules of natural justice and was required to act with as little formality and technicality as the matter permitted.¹⁰³ Under normal VCAT procedure at the time, the applicant was required to put his case first. In his appeal, the applicant relied on *Towie v Medical Practitioners Board*,¹⁰⁴ where the Court of Appeal had reviewed a VCAT decision in which that same procedure had been followed. In that case, the court had found that requiring an applicant to present their case first 'would not generally be appropriate' where an applicant 'is a person who is or may be exposed to a penalty'.¹⁰⁵ Applying the findings of *Towie v Medical Practitioners Board*,¹⁰⁶ the Court of Appeal in *MH6 v Mental Health Review Board & Anor* found:

Procedural fairness would require that an involuntary detainee be given an opportunity to hear and respond to evidence that provides the jurisdictional basis for continued confinement.¹⁰⁷

This meant that it would 'not normally be appropriate' for a person facing an involuntary treatment order to be required to present his or

her evidence first in a mental health review tribunal matter.¹⁰⁸ The Court of Appeal explained:

An adequate opportunity [to be heard in accordance with the hearing rule] will not have been afforded unless the party knows what is alleged, knows what evidence is relied upon to substantiate the allegation, and has an opportunity to respond to the case against them and put forward their own case.¹⁰⁹

Even where the process has an inquisitorial component, a party against whom adverse findings may be made, having been apprised of the issues, must be given the opportunity to put evidence and argument in response, even though there is no 'case' being advanced against the party.¹¹⁰ This would tend to suggest that the rules of procedural fairness require that parties before the QMHRT be made aware of, and have the opportunity to challenge, any evidence that may be used in the determination of their involuntary treatment, which is consistent with the views of our participants.

Admission of evidence and hearsay

Most Australian tribunals, including the QMHRT, are not bound by the rules of evidence.¹¹¹ This, as Gleeson CJ and Handley J have stated, means that a tribunal 'will not err in law merely because it acts on evidence which would not be admissible in a court or because there is no legally admissible evidence to support any of its findings'.¹¹² Nevertheless, this does not mean that there are no restrictions at all on the use of evidence by tribunals.¹¹³ To be admitted, evidence must have probative value,¹¹⁴ and a tribunal decision must be based on evidence 'which is reasonably capable of sustaining it'.¹¹⁵ In a frequently cited early pronouncement, Evatt J found that when rules of evidence are expressly excluded from application, that does not mean that 'all rules of evidence may be ignored as of no account'.¹¹⁶ More recently, it has been stated that 'the policies which

underpin those principles and rules should be borne in mind when a decision is made on the admissibility or weight of a piece of evidence'.¹¹⁷ However, Brennan J cautioned that expressly excluded provisions must not 'creep back through a domestic procedural rule'.¹¹⁸ Similarly, a tribunal's reliance on hearsay evidence does not invalidate a decision on that basis alone. However, tribunals cannot treat hearsay evidence as they would other sources of evidence: its quality as a form of evidence that is inherently less reliable must be taken into consideration.¹¹⁹ In the context of mental health review tribunals, it is important that the person be given an opportunity to challenge hearsay evidence; if such an opportunity is not given, that may preclude its admissibility.¹²⁰

Therefore, whilst tribunals such as the QMHRT are free to accept evidence that would not be admissible in a court, they must pay careful attention to the manner in which they use such evidence. Our participants' views regarding the use of the evidence contained in clinical reports give cause for concern. They said that the clinical reports upon which the tribunal tends to rely in making its decisions are often outdated, inaccurate and include 'cut and pasted' anecdotes and unsubstantiated comments.¹²¹ Similar concerns have been raised in the literature about the general quality of the medical evidence that is presented to mental health review tribunals.¹²² In her cross-jurisdictional study of mental health court and tribunal proceedings, Fritze found that if the court or tribunal challenged the treating team's evidence, including on issues such as hearsay, the quality of proceedings improved.¹²³ The case law would suggest that the QMHRT should be submitting the contents of these reports to a higher level of scrutiny, particularly as regards hearsay evidence.

'Rubber stamping'

Whilst the QMHRT's power to inform itself in any way it considers appropriate allows it to take an active role in proceedings, it must still ensure that it remains independent and

rigorous in its processes. Only two of our participants used the word 'biased' to describe the QMHRT's decision-making processes, however, many described its processes as a mere 'rubber stamp' of the treatment team's recommendation.

The most commonly expressed concern in the literature on mental health review tribunals relates to whether these tribunals provide a genuinely independent review of the medical evidence.¹²⁴ In most jurisdictions, mental health review tribunals are asked to consider involuntary treatment orders that have already been made by a psychiatrist or psychiatrists, and it is commonly alleged that these tribunals have a strong tendency to confirm existing treatment orders;¹²⁵ in fact, the process is often described as a 'rubber stamp' of the views of the treating psychiatrists, in which the evidence presented by the treating psychiatrists is insufficiently challenged.¹²⁶ Existing scholarship provides various examples of how this manifests, such as the inappropriate acceptance of hearsay evidence,¹²⁷ acceptance of medical opinion as fact¹²⁸ and failure to allow cross-examination of medical evidence.¹²⁹

Whilst there are no reported Australian decisions related to mental health tribunals on point, this issue was discussed in *XYZ v State Trustees*,¹³⁰ where the Victorian Supreme Court heard an appeal from a VCAT decision to make an administration order for the plaintiff. The VCAT decision had relied heavily on a neuropsychological report stating that the adult lacked financial capacity. The Supreme Court found that VCAT had erred by placing 'undue reliance' on the neuropsychological report despite other available evidence, including that from the adult himself,¹³¹ and by treating the neuropsychological report as 'presumptively correct'.¹³² In *S v State Administrative Tribunal of Western Australia*, Em Heenan J noted that the *Briginshaw* standard¹³³ should have been adopted when deciding that the appellant lacked capacity and that a limited trustee and a limited administrator should be appointed, given the 'seriousness of

the allegations made and gravity of the adverse consequences for the appellant'.¹³⁴

Therefore, given the significance of the allegations made, and the gravity of the consequences of QMHRT decisions, it would seem that 'rubber stamping' the decision of a doctor, such that it appears that the tribunal has abdicated its decision-making role, may constitute an error of law. Yet, our participants said that this happens regularly in the QMHRT. Uncritical acceptance of medical evidence from the treating team is particularly problematic in this context because, as our participants noted, even when the patient has legal representation, clients in the mental healthcare system face considerable practical difficulties in finding a second medical opinion to challenge that evidence.

Conclusion and recommendations

The task of providing a tribunal procedure that is both fair on one hand, and sufficiently informal and efficient on the other, is obviously very difficult. In the context of decisions about involuntary treatment for people with mental illness, it is even more so. Nevertheless, the view of our participants was that there is significant room for improvement in QMHRT practice with regards to its obligation to provide procedural fairness.

Fairness of process is of heightened importance when decisions are being made that restrict a person's liberty. Moreover, regardless of the forum, decision-makers must address the applicable legislative criteria in a methodical and deliberate manner. It is critical to ensure that clients are communicated with before the hearing and after the decision is made. The legislative scheme in Queensland places the central burden of that on the client's treating team, but the tribunal itself, and legal representatives, also play a role. Communication with people with mental illness must obviously take into consideration their particular difficulties, including the effects of their impairments, medications and their vulnerability generally, on

their capacity to understand and engage with the process. The recent decision to commence recording proceedings will likely improve transparency, accountability and predictability of QMHRT proceedings and decisions.

That QMHRT proceedings may not be sufficiently challenging evidence put by the treating doctors who made the initial orders is perhaps a more difficult issue to address. However, for the Tribunal to genuinely provide an independent review of the legislative criteria for treatment authorities and forensic orders, evidence from the treating team must be open to challenge.

Of course, further research is required to determine whether or not these concerns are shared by other stakeholders, including treating psychiatrists, tribunal members and people with mental illness themselves.

Ethical standards

Declaration of conflicts of interest

Sam Boyle has declared no conflicts of interest.

Tamara Walsh has declared no conflicts of interest.

Ethical approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the Queensland University of Technology and University of Queensland's research ethics committees and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent

Informed consent was obtained from all individual participants included in the study.

Notes

1. See *Mental Health Act 2016* (Qld) s 704(1); *Mental Health Act 2007* (NSW) s 140(1); *Mental Health Act 2014* (Vic) s 152(1); *Mental Health Act 2013* (Tas) s

- 167(1); *Mental Health Act 2014* (WA) s 380; and *Mental Health and Related Services Act 1998* (NT) s 118.
2. See eg *Mental Health Act 2016* (Qld) ss 419, 441. In South Australia decisions about involuntary treatment for mental illnesses are made by the South Australian Civil and Administrative Tribunal (SACAT); see eg *Mental Health Act 2009* (SA) ss 3(1), 16. In the ACT these decisions are made by the ACT Civil and Administrative Tribunal (ACAT); see eg *Mental Health Act 2015* (ACT) s 58(2). The provisions relating to evidence and procedure that apply to SACAT and ACAT when making these decisions are equivalent to those that apply to mental health review tribunals: *ACT Civil and Administrative Tribunal Act 2008* (ACT) ss 8, 24(2); *South Australian Civil and Administrative Tribunal Act 2013* (SA) s 39(1).
3. Administrative Review Council, *Better Decisions: Review of Commonwealth Merits Review Tribunals*, Report No 39 (1995) [3.9].
4. Robin Creyke, 'Tribunals – "Carving Out the Philosophy of Their Existence": The Challenge for the 21st Century' (2012) 71 *Australian Institute of Administrative Law Forum* 19, 21–22.
5. *EO v Mental Health Review Board* [2000] WASC 203 [39].
6. Piers Gooding and others, 'Unfitness to Stand Trial and the Indefinite Detention of Persons with Cognitive Disabilities in Australia: Human Rights Challenges and Proposals for Change' (2017) 40(3) *Melbourne Univ Law Rev* 816, 851–52. Note, however, that one of the objects of the *Queensland Mental Health Act* is to divert people from the criminal justice system: *Mental Health Act 2016* (Qld) s 3(1)(b).
7. In Queensland, the Mental Health Review Tribunal is required to observe the rules of natural justice: *Mental Health Act 2016* (Qld) s 733(3)(a).
8. Mary Donnelly, 'Review of Treatment Decisions: Respecting Rights or Jumping Through Hoops?' in Bernadette McSherry and Penny Weller (eds), *Rethinking Rights-Based Mental Health Laws* (Hart Publishing 2010) 283.
9. We assess different aspects of QMHRT decision-making in other papers, see Boyle, Walsh and Nelson, 'A Study into

- the Operation of the Queensland Mental Health Tribunal' (2020) (forthcoming) and Boyle, 'Involuntary Electroconvulsive Therapy and Human Rights Obligations on Mental Health Tribunals' (2020) (forthcoming).
10. Tom R Tyler, 'Procedural Justice, Legitimacy, and the Effective Rule of Law' (2003) 30 *Crime Justice* 283.
 11. Bruce Winick, *Civil Commitment: A Therapeutic Jurisprudence Model* (Carolina Academic Press 2005) 145; James D Livingston and others, 'Forensic Mental Health Tribunals: A Qualitative Study of Participants' Experiences and Views' (2016) 22(2) *Psychol Publ Pol Law* 173.
 12. Margaret Allars, 'Neutrality, the Judicial Paradigm and Tribunal Procedure' (1991) 13 *Sydney Law Rev* 377, 392.
 13. Katey Thom and Ivana Nakarada-Kordic, 'Mental Health Review Tribunals in Action: A Systemic Review of the Empirical Literature' (2014) 21(1) *Psychiatry Psychol Law* 112, 123.
 14. Procedural fairness is the term favoured in Australian courts when assessing administrative decisions rather than the term 'natural justice', with which it can be 'equated'; *Kioa v West* [1985] HCA 81, (1985) 159 CLR 550, 583. Procedural fairness may also be compared to the 'parallel' concept of 'due process' that exists in the American system: Frederick F Schauer, 'English Natural Justice and American Due Process: An Analytical Comparison' (1976) 18 *William Mary Law Rev* 47.
 15. Terry Carney and others, 'Mental Health Tribunals: "TJ" Implications of Weight Fairness, Freedom, Protection and Treatment' (2007) 17 *J Judicial Admin* 46.
 16. See Michael L Perlin's discussions on 'sanism' in eg 'Half-Wracked Prejudice Leaped Forth: Sanism, Pretextuality and Why and How Mental Disability Law Developed as It Did' (1999) 10 *J Contemp Legal Issues* 3.
 17. Eg Neil Rees, 'International Human Rights Obligations and Mental Health Review Tribunals' (2003) 10(1) *Psychiatry Psychol Law* 33.
 18. Ian Freckelton has examined two Supreme Court decisions on procedural fairness and mental health tribunal decisions: 'Civil Commitment: Due Process, Procedural Fairness and the Quality of Decision-Making' [2001] 8(1) *Psychiatry Psychol Law* 105.
 19. Laurence W Maher, 'The Australian Experiment in Merits Review Tribunals' (1989) 12(2) *Law Context* 73; L Curtis, 'Crossing the Frontiers Between Law and Administration' (1989) 58 *Canberra Bull Publ Admin* 55.
 20. *Mental Health Act 2016* (Qld) s 705(2).
 21. Mental Health Review Tribunal, *Annual Report 2017–2018* (Queensland Government, 2018) 8.
 22. *Mental Health Act 2016* (Qld) s 708.
 23. Duncan Kerr, 'State Tribunals and Ch III of the Australian Constitution' (2007) 31 *Melbourne Univ Law Rev* 622.
 24. *Mental Health Act 2016* (Qld) s 705(1)(a)(ii).
 25. *Solomons v District Court of NSW* (2002) 211 CLR 119; 192 ALR 217 [49]. As such, it meets Rees' criterion for being a 'court substitute tribunal'; see Neil Rees, 'Procedure and Evidence in "Court Substitute" Tribunals' (2006) 28 *Austr Bar Rev* 41, 43.
 26. See *Director of Housing v Sudi* [2011] VSCA 266 [208]. See also Rebecca Ananian-Welsh, 'CATs, Courts and the Constitution: The Place of Super-Tribunals in the National Judicial System' (2020) 43(4) *Melbourne Univ Law Rev*.
 27. *Mental Health Act 2016* (Qld) s 546(2).
 28. Although the Notice of Appeal form does require the person to specify their grounds of appeal: <https://www.courts.qld.gov.au/_data/assets/pdf_file/0019/511264/mha-2016-f-4.pdf> accessed 9 July 2019
 29. See *Mental Health Act 2016* (Qld) s 733; cf *Mental Health Act 2000* (Qld) s 459. A significant difference in the *Mental Health Act 2016* (Qld) relates to the 'treatment criteria' the Tribunal must apply when determining whether to confirm a 'treatment authority'. A 'treatment authority' (previously known as an involuntary treatment order), is 'a lawful authority to provide treatment and care to a person who has a mental illness' but lacks the capacity to consent to be treated: *Mental Health Act 2016* (Qld) s 18(1). Under the new *Act*, if a person has capacity to consent to be treated for their illness, the 'treatment criteria' are not met, and they cannot be subjected to involuntary treatment under a treatment authority: *Mental Health Act 2016* ss

- 12(1)(b), 14; cf *Mental Health Act 2000* (Qld) s 14(1)(f)(ii). Note that the *Act* now states that a person can have capacity to consent to treatment even though the person decides not to receive treatment: s 14(2). For a person to meet the treatment criteria, there must also be 'a risk of imminent serious harm to the person or others', however, this was also the case under the old *Act*: *Mental Health Act 2016* (Qld).
30. *Mental Health Act 2016* (Qld) s 739.
 31. *Mental Health Act 2016* (Qld) s 740(2), (3).
 32. *Mental Health Act 2016* (Qld) s 740(6).
 33. *Mental Health Act 2016* (Qld) s 739.
 34. In which the Queensland Mental Health Court has determined that a person was either of unsound mind when an offence was allegedly committed, or is unfit for trial and the unfitness is permanent: *Mental Health Act 2016* s 134.
 35. *Mental Health Act 2016* s 441(1).
 36. *Mental Health Act 2016* s 444.
 37. Mental Health Review Tribunal, *Annual Report 2018–2019* (Report, 2019) 21 <https://www.mhrt.qld.gov.au/sites/default/files/2019-10/MHRT%20Annual%20Report%202018-19_191010%20-%20Tabled%20Report.pdf> accessed 9 September 2019
 38. *Mental Health Act 2016* (Qld) s 733(3)(d).
 39. *Mental Health Act 2016* (Qld) s 733(3)(c).
 40. *Mental Health Act 2016* (Qld) s 733(3)(b) (emphasis added).
 41. *Mental Health Act 2016* (Qld) s 733(2).
 42. *Mental Health Act 2016* (Qld) s 733(3)(a).
 43. *Annetts v McCann* [1990] HCA 57; (1990) 170 CLR 596, 598; *Saaed v Minister for Immigration and Citizenship* [2010] HCA 23 [2].
 44. See *Director of Housing v Sudi* [2011] VSCA 266 [208].
 45. *Kioa v West* [1985] HCA 81; (1985) 159 CLR 550, 585.
 46. Matthew Groves, 'The Power of an Administrative Tribunal to Inform Itself' (2015) 22 Austr J Admin Law 236, 241.
 47. Mark Aronson and Matthew Groves, *Judicial Review of Administrative Action* (5th edn, Lawbook 2013) 398–99.
 48. See eg *R v Small Claims Tribunal; Ex parte Cameron* [1976] VR 427, 432.
 49. See eg s 418(2).
 50. *Mental Health Act 2016* (Qld) s 723(3). Note that the treating practitioner can apply for a confidentiality order in respect of the report: s 723(4).
 51. *Saaed v Minister for Immigration and Citizenship* [2010] HCA 23 [2], [20].
 52. *Mental Health Act 2016* (Qld) s 5(b).
 53. *Mental Health Act 2016* (Qld) s 5(d). As to the right to legal representation in tribunal proceedings, see Michael Hocken, Paul Latimer and Stephen Marsden, 'Legal Representation in Australia Before Tribunals, Committees and Other Bodies' (2007) 14(2) Murdoch Univ Electronic J Law 122.
 54. Rees (n 17) 58.
 55. *Johnson v Johnson* [2000] HCA 48; 201 CLR 488; 174 ALR 655; 74 ALJR 1380 [11]; *Livesey v New South Wales Bar Association* [1983] HCA 17; (1983) 151 CLR 288 [7].
 56. *Minister for Immigration and Multicultural Affairs v Jia* [2001] HCA 17; (2001) 205 CLR 507; 178 ALR 421, 438.
 57. *Isbester v Knox City Council* [2015] HCA 20; 255 CLR 135 [23]; *Re Minister for Immigration and Multicultural Affairs; Ex parte Epeabaka* (2001) 206 CLR 128; 179 ALR 296 at [27]. See also *CDK16 v Minister for Immigration & Anor* [2018] FCCA 3626 [158]; *SZSNU v Minister for Immigration & Anor* [2013] FCCA 1219 [30].
 58. *SZRUI v Minister for Immigration, Multicultural Affairs and Citizenship* [2013] FCAFC 80 [33]; *Titan v Babic* (1994) 126 ALR 455, 464.
 59. Note that in 2017/18, the QMHRT heard 12,335 matters and appointed legal representatives in 21% (n=2541) of those: Mental Health Review Tribunal (2018) 28.
 60. Anonymity of all participants was a requirement of our research ethics approval. For this reason, we cannot reveal which agency declined to participate in the research.
 61. Sue Wilkinson, 'Focus Group Methodology: A Review' (1998) 1(3) Int J Soc Res Methodol 181, 190–91.
 62. Tobian Nyumba and others, 'The Use of Focus Group Discussion Methodology: Insights from Two Decades of Application in Conservation' (2018) 9(1) Methods Ecol Evol 20, 21.
 63. Nyumba and others (n 62) 27.
 64. Jenny Kitzinger, 'The Methodology of Focus Groups: The Importance of

- Interaction Between Research Participants' (1994) 16(1) *Social Health Illness* 103, 112.
65. Wilkinson (n 61) 184.
 66. The Queensland University of Technology Human Research Ethics Committee (#180001004) and The University of Queensland Human Research Ethics Committee (#2018002284).
 67. We sought permission from the president of the Mental Health Review Tribunal to undertake an observational study of the Tribunal's processes, however, we were denied permission to undertake this study.
 68. As to content analysis, see Wilkinson (n 61) 195–96.
 69. This is required under the *Mental Health Act 2016* (Qld) ss 418(2), 471(2), 487(2), 508(2)(b).
 70. The *Act* sets a 21-day limit: *Mental Health Act 2016* (Qld) s 756(2).
 71. 'Electronic Audio Recording Project', *Mental Health Review Tribunal* (Web Page) accessed 25 May 2020. <<https://www.mhrt.qld.gov.au/information-about/electronic-audio-recording-project>> In its 2018/19 Annual Report, the Queensland Mental Health Review Tribunal stated that it was 'currently evaluating' feedback from the survey and 'investigating the possible mechanisms by which electronic recording could be implemented': *Mental Health Review Tribunal* (n 37) 21.
 72. 'Published Statements of Reasons', *Mental Health Review Tribunal* (Web Page) <<https://www.mhrt.qld.gov.au/resources/published-statement-of-reasons>> accessed 10 October 2019
 73. Terry Carney and others, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment* (Themis Press 2011) 41. There is also considerable support for human rights law as an avenue for the improved treatment of people with mental illnesses, see for example Peter Bartlett, Oliver Lewis and Oliver Thorold, *Mental Disability and the European Convention on Human Rights* (Martinus Nijhoff Publishers 2007).
 74. *PBU and NJE v Mental Health Tribunal* [2018] VSC 564 [276]. In that case, Bell J held that the gravity of the consequences to the individual subject to involuntary mental health treatment meant that the treatment criteria needed to be 'convincingly shown'.
 75. *Human Rights Act 2019* (Qld) s 31(1). In Victoria, see *Charter of Human Rights and Responsibilities 2006* (Vic) s 24(1).
 76. Justice Emilios Kyrrou, 'VCAT's Natural Justice Obligations' (Paper delivered at the VCAT, 23 June 2010) <<http://classic.austlii.edu.au/au/journals/VicJSchol/2010/23.pdf>> accessed 27 May 2019. [29].
 77. Terry Carney, David Tait and Fleur Beaupert, 'Pushing the Boundaries: Realising Rights Through Mental Health Tribunal Processes?' [2008] 30 *Sydney Law Rev* 329, 336–37.
 78. Chief Justice Robert French, 'Procedural Fairness: Indispensable to Justice?' (Sir Anthony Mason Lecture, The University of Melbourne Law School, 7 October 2010) <www.hcourt.gov.au/assets/publications/speeches/current-justices/frenchcj/frenchcj07oct10.pdf> accessed 27 May 2019
 79. French (n 78).
 80. French (n 78).
 81. Winick, *Civil Commitment* (n 11) 145.
 82. Carney and others, *Australian Mental Health Tribunals* (n 73) 152.
 83. Mark Aronson, Matthew Grove and Gregory Weeks, *Judicial Review of Administrative Action and Government Liability* (6th edn, Thomson Reuters 2016) 532.
 84. *Nguyen v Refugee Review Tribunal* (1997) 74 FCR 311.
 85. Fn 180. It can be noted that the Federal Court in *SZRMQ v Minister for Immigration and Border Protection* [2013] FCAFC 142 found that mis-translation during proceedings may amount to procedural unfairness, depending on the precise circumstances of the case.
 86. *EO v Mental Health Review Board* [2000] WASC 203.
 87. *Mental Health Act 1996* (WA) sch 2, cl 7–8.
 88. *EO v Mental Health Review Board* [2000] WASC 203 [30].
 89. *EO v Mental Health Review Board* [2000] WASC 203 [32].
 90. *EO v Mental Health Review Board* [2000] WASC 203 [35].
 91. *EO v Mental Health Review Board* [2000] WASC 203 [40]–[41].
 92. Carney and others, 'Mental Health Tribunals' (n 15) 57, citing Victoria, Auditor-General, *Mental Health Services for People in Crisis* (Auditor General, Victoria, 2002); Charles D Parry and Eric

- Turkheimer, 'Length of Hospitalization and Outcome of Commitment and Recommitment Hearings' (1992) 43 *Hospital Commun Psychiatry* 65, 66.
93. Carney and others, *Australian Mental Health Tribunals* (n 73) 157.
 94. (1893) 6 R 67 (HL).
 95. *Re Minister for Immigration and Multicultural Affairs; Ex parte Applicant S154/2002* (2003) 77 ALRJ 1909 [57]; *Sullivan v Civil Aviation Safety Authority* [2014] FCAFC 93 [149].
 96. *MH6 v Mental Health Review Board & Anor* [2009] VSCA 184 [20].
 97. *Secretary, Department of Social Security v Murphy* (1998) 52 ALD 268; *Ileris v Comcare* (1999) 56 ALD 301 [43]; *Casey v Repatriation Commission* (1995) 39 ALD 34, 38.
 98. *EO v Mental Health Review Board* [2000] WASC 203.
 99. *EO v Mental Health Review Board* [2000] WASC 203 [37].
 100. Rees (n 25) 76, fn 246.
 101. Juliet Lucy, 'Merits Review and the 21st Century Tribunal' (2017) 24 *Austr J Admin Law* 121, 132; Rees (n 25), fn 246. See *Rawson Finances Pty Ltd v Commissioner of Taxation* (2013) 93 ATR 775; [2013] FCAFC 26 [73].
 102. [2009] VSCA 184.
 103. *Victorian Civil and Administrative Tribunal Act 1998* (Vic) s 91(1). The VCAT review was by way of a full rehearing of the original application to the Mental Health Review Board: *MH6 v Mental Health Review Board* [2008] VSC 345 [6]–[7]. Note that the *Mental Health Act 1986* (Vic) has since been repealed and replaced by the *Mental Health Act 2014* (Vic). Original applications are now heard by the Mental Health Tribunal.
 104. *Towie v Medical Practitioners Board* [2008] VSCA 157.
 105. *Towie v Medical Practitioners Board* [2008] VSCA 157 [9].
 106. *Towie v Medical Practitioners Board* [2008] VSCA 157.
 107. *MH6 v Mental Health Review Board & Anor* [2009] VSCA 184 [26].
 108. *MH6 v Mental Health Review Board & Anor* [2009] VSCA 184 [26].
 109. *MH6 v Mental Health Review Board & Anor* [2009] VSCA 184 [36], citing *Towie v Medical Practitioners Board* [2008] VSCA 157.
 110. *MH6 v Mental Health Review Board & Anor* [2009] VSCA 184 [28]. Note that the Court of Appeal did not overturn the VCAT decision in *MH6 v Mental Health Review Board & Anor*. It found that the applicant was not disadvantaged by the order of presentation of evidence because he did not call any medical evidence. Also, the procedure followed did not deny the applicant the opportunity to contest the evidence presented, because the relevant material had already been 'fully exposed and tested' in the earlier Mental Health Review Board decision: [33]–[34].
 111. *Mental Health Act 2016* (Qld) s 733(3)(c). See also eg *Mental Health Act 2014* (Vic) s 181(1)(a).
 112. *Qantas Airways Ltd v Gubbins* (1992) 28 ALD 538, 542.
 113. Gleeson JA and Hanley J note that it is 'not unfettered': *Qantas Airways Ltd v Gubbins* (1992) 28 ALD 538, 542.
 114. *R v Australian Stevedoring Industry Board; Ex parte Melbourne Stevedoring Co Pty Ltd* (1953) 88 CLR 100, 119; [1953] ALR 461; *Australian Broadcasting Tribunal v Bond* (1990) 170 CLR 321, 356; 94 ALR 11.
 115. *Minister for Immigration and Ethnic Affairs v Pochi* (1979) 44 FLR 41, 67; 31 ALR 666. Note that the requirement to act on logically probative evidence is not strictly considered an element of procedural fairness. Nevertheless, it is grounds for review of decision that is closely linked to that requirement. See Aronson and Groves (n 47) 400–402.
 116. *R v War Pensions Entitlement Appeals Tribunal; ex parte Bott* (1933) 50 CLR 228, 256.
 117. *Ileris v Comcare* (1999) 56 ALD 301 [43]. See also *Bannon v The Queen* (1995) 70 ALJR 25.
 118. *Re Pochi and Minister for Immigration and Ethnic Affairs* (1979) 26 ALR 247, 256; 2 ALD 33, 41.
 119. *Re Saverio Barbaro and Minister for Immigration and Ethnic Affairs* (1980) 3 ALD 1 [4]–[5]. For example in *A & B v Director of Family Services* (1996) 132 FLR 172, a magistrate's decision was overturned, in part, for reliance on hearsay evidence, even though in the jurisdiction (child welfare) the magistrate was not bound by the rules of evidence.
 120. *Ileris v Comcare* (1999) 56 ALD 301 [43].

121. Participants in Carney et al's study similarly stated that hearsay evidence was sometimes used inappropriately: Carney and others, *Australian Mental Health Tribunals* (n 73) 201.
122. Carney and others, *Australian Mental Health Tribunals* (n 73) 210–15; Genevra Richardson and David Machin, 'Judicial Review and Tribunal Decision Making: A Study of the Mental Health Review Tribunal' (2000) Autumn Public Law 494. The same arguments have been made with respect to social workers' affidavits in child protection matters: see Tamara Walsh and Heather Douglas, 'Lawyers, Advocacy and Child Protection' (2011) 35(2) Melbourne Univ Law Rev 621.
123. Eleanore Fritze, *Shining a Light behind Closed Doors* (2015, Victorian Legal Aid).
124. See Thom and Nakarada-Kordic (n 13) for an overview of the literature.
125. Genevra Richardson and David Machin, 'Doctors on Tribunals: A Confusion of Roles' (2000) 176 British J Psychiatry 110, 115; Amar Shah, 'Is the Mental Health Review Tribunal Inherently Unfair to Patients?' (2010) Psychiatry Psychol Law 17, 25–31; Sameer Sarkar and Gwen Adshead, 'Black Robes and White Coats: Who Will Win the New Mental Health Tribunals?' (2005) 186(2) Brit J Psychiatry 96, 96–97; Ian Freckelton, 'Therapeutic Jurisprudence Misunderstood and Misrepresented: The Price and Risks of Influence' (2008) 30(2) Thomas Jefferson Law Rev 575, 587; Carney and others, *Australian Mental Health Tribunals* (n 73) 52–57; Liv Zetterberg, Stefan Sjöström and Urban Markström, 'The Compliant Court: Procedural Fairness and Social Control in Compulsory Community Care' (2014) 37 Int J Law Psychiatry 543, 547; Sol Jaworowski and Rumiana Guneva, 'Decision-Making in Community Treatment Orders: A Comparison of Clinicians and Mental Health Review Board Members' (2002) 10 Australas Psychiatry 29.
126. Bruce Winick, 'Therapeutic Jurisprudence and the Civil Commitment Hearing' (1999) 10 J Contemp Legal Issues 37, 41. See also Michael L Perlin, 'Who Will Judge the Many When the Game Is Through: Considering the Profound Differences Between Mental Health Courts and Traditional Involuntary Civil Commitment Courts' (2017–2018) 41 Seattle Univ Law Rev 937, 943.
127. Penelope Weller, 'Taking a Reflexive Turn: Non-adversarial Justice and Mental Health Review Tribunals' (2011) 37(1) Monash Univ Law Rev 81, 95.
128. Sarkar and Adshead (n 125) 96–97.
129. Jill Peay, *Tribunals on Trial: A Study of Decision-Making Under the Mental Health Act 1983* (Clarendon Press, 1989) 93; Shah (n 125).
130. *XYZ v State Trustees* [2006] VSC 444.
131. *XYZ v State Trustees* [2006] VSC 444 [47].
132. *XYZ v State Trustees* [2006] VSC 444 [53].
133. *Briginshaw v Briginshaw* (1938) 60 CLR 336, 361–62.
134. *S v State Administrative Tribunal of Western Australia* (No. 2) [2012] WASC 306.