**WEBINAR - Representing clients before the Mental Health Review Tribunal**

The Mental Health Review Tribunal (**MHRT**) reviews the validity of orders authorising involuntary mental health treatment and detention. It serves to protect vulnerable people with mental illness from arbitrary state action. Only 2.27% of patients at 10,972 MHRT hearings in 2011-12 were represented (NSW patients are represented in 63% of civil hearings, and 98% of NT patients are represented). This session will provide an introduction to lawyers/advocates to assist clients to assert their rights before the MHRT.

**Overview**

* *About QAI* - is an independent, community-based systems and legal advocacy organisation for people with disability in Queensland.
* *About me* - principal solicitor. Started in 2010 specifically to start our mental health legal service. During that time, the service has engaged in 400+ hearings
* *Today’s session* – hope to provide some practical insight into providing representation before the MHRT - practice and procedure. Not my intention to go into the nitty gritty of particular treatment criteria, but happy to do so if requested. I also sent out an email to then registered participants in today’s session requesting their input for today’s content, thank you very much for the response. Raised some very interesting issues that I might not have otherwise covered, so I hope to get to those as well. Outline of the agenda:
	+ General observations about mental health law and representing at the Mental Health Review Tribunal
	+ Scope of powers

**General observations**

*Representation statistics*

* Thank you very much for your interest in today’s talk. As you will be aware from the synopsis, only 2.3% of matters before the MHRT in 2011/12 were attended by legal representation. That’s about 250 hearings out of 11000.
* In contrast,
	+ Qld: AG attends 50% of forensic hearings.
	+ NSW: 63% civil hearings, 98% of forensic hearings
	+ NT: 100%
	+ Vic: 10% of civil hearings.
* On the available data (some states do not publish) Qld is the worst for legal representation.
* The more people we can get interested in this area, the better.

*Importance of legal representation*

* The MHRT practices “therapeutic jurisprudence” – that is, the MHRT’s role is a rehabilitative one, with consideration given to how the application of the law impacts on the whole person.
* While there is a right to legal representation, fair to say that the MHRT does not actively encourage representation in most cases. The dvd sent to first time patients (available online) highlights the informality of proceedings and promotes self-representation.
* However, the Tribunal is still charged with the important responsibility of determining issues of liberty, freedom of choice and bodily integrity. It serves to protect vulnerable people with mental illness from arbitrary state action.
* Benefits of legal representation goes beyond just “getting what the client wants”. It can:
* Improves the quality and efficiency of tribunal hearings by summarising the client’s case, testing the evidence and highlighting the legal issues.
* Supports vulnerable people with mental illness through a legal process which determines their fundamental human rights. Many patients report high levels of anxiety about tribunal hearings and, particularly those without a support person, find it an intimidating process. [[1]](#footnote-1)
* Increases patient attendance at hearings. Anecdotally, many of QAI’s clients would not attend hearings without the attendance of their lawyer or advocate. For some, we are their form of only support. For others, a lawyer ensures a fair hearing and their voices heard, not just a rubber stamp.
* Enables the treating team to focus on their role of providing evidence, without feeling responsible to the patient to represent their views and wishes.
* Improves the patient’s perception of the review process.
* Improves the patient’s understanding of the review process, the law and their rights.
* Can improve understanding and communication between patient and treating team.
* Reduces incidences of appeal.

*Review of the Mental Health Act*

* MHA is currently undergoing extensive review.
* Submissions taken mid last year, with discussion paper due out some time in March and open to further submission.
* Expectation of new legislation in 2015?
* One note:
	+ The MHA was written in 2000 using a medical model / “best interests” approach.
	+ Since then we have had enactment of the CRPD which is more of a capacity based framework, ie, people need to be supported to make their own decisions, and if they have capacity, be allowed to make even poor decisions.
	+ Interesting to see how this pans out.

**Scope of powers of MHRT**

Defined by the*Mental Health Act 2000*

Broadly:

* Review of ITOs – in first 6 weeks then every 6 months
* Review of FOs – every 6 months,
* Fitness for Trial – every 3 months in first year and then every 6 months
* Applications to move out of Qld
* Applications for ECT
* Confidentiality orders
* Exclusion of visitor appeals

ITOs and FOs account for: 92% of all hearings.

The Tribunal do not engage in:

* Questions of medication, treatment plans (although we would argue that if the medication is not working, then against principles of the Act to continue the ITO).
* Review of **EEOs, JEOs and R&Rs** – if the criteria for an ITO have been met, then does not matter if the client was “unlawfully” brought to the attention of health services.
* Seclusion or restraint
* In relation to ITOs: Rarely order second opinions (s 190), change of categories (s 191(a)), LCT (s 191(b)(ii), transfer (even if this would facilitate a bed being made available), amend or revoke monitoring condition (s 191)(2)(d)) despite having power to do so.

One question that was raised was – what can you do for a person who believes their EEO, JEO, or R&R was invalidly made?

* Focus of our limited service has been on MHRT hearings and ITOs and FOs, so limited practical experience.
* HQCC – 1 year limitation. One person we know of has been successful in having his complaint investigated, although we are not certain of the outcome that would be achieved.
* CMC
* Judicial review? Value in seeking JR may be limited:
	+ Send back to original decision maker to make decision.
	+ JEOs (7 day validity), EEOs valid for 6 hours, R&R (7 days validity) valid for max 72 hours.
	+ Could say invalidly made leading to other legal action?
	+ Cost, financial and emotional, may be too much for individual to consider pursuing claim.
	+ Comments?
* RTI relevant documents – JEOs difficult to get.
* NB. JEO process should be subject of significant reform under MHA review given problems that have arisen in respect of this.

**Initial contact with client and MHRT**

What we do when a client calls us for assistance on an ITO or forensic order:

1. Is it something the MHRT can help with?
2. When is the next hearing, is there value in applying for an early hearing?
3. Get written authority from client.
4. Send written authority to MHRT hc@mhrt.qld.gov.au advising that you now act for the client and request all documents relevant to the matter, including hearing notice once it’s prepared.

MHRT registry:

* Hearings are held at hospitals and community mental health centres.
* A number of hearings coordinators at the MHRT registry, each responsible for particular health facilities.
* Differing levels of service depending on which hearings coordinator. May have to chase up for documents, including decision notice.
* Once on the record as legal rep, will likely stay on there for the next periodic review (will get hearing notice or contact from MHRT to ask whether you are still acting.)

Contacting the doctor / case manager:

* Not until we receive documents
* Not necessraily

**Who can attend the Tribunal hearing?**

*Patient*

* Patient has a right to attend all hearings about them, except for confidentiality order hearings and exclusion of visitor appeals. Chapter 12 Part 4
* MHRT may proceed in absence of patient if Tribunal reasonably believes patient is absent because of the patient’s own free will or is unfit to appear **AND** tribunal is satisfied that it is appropriate and expedient to do so (s 456). Eg, if patient is in seclusion. In these circumstances, based on client’s instructions:
	+ Can jump up and down
	+ Ask patient attend by telephone (listening in)
	+ Adjourn the matter
	+ Ask Tribunal to go and see the patient at the end of the hearing to get his views and opinions.
* Patients in prison – often will attend in person with escort to The Park. Otherwise by telephone. Have not done v/c before but should be possible. Prisons have difficulties in having staff to escort so they can turn up really late. May want to liaise with MHRT and//or prison to facilitate attendance at hearing.

*Legal representative*

* Right to legal representation
* No need to apply for leave.
* Can appear in person (preferable) but can also request telephone or video/conference (V/c only available if MHRT members are appearing by v/c or AG is attending by v/c)

*Agent*

* With leave of the MHRT.
* No need for legal training.
* Would still pre-warn the MHRT that an agent is coming and be prepared to make submissions on the point, but unlikely to be an issue. Will be up to specific tribunal makeup on the day.

*Allied persons.*

* Right to attend and represent patient’s views wishes and interests.
* Appointed by patient, or if no capacity, administrator of MHS.
* No access to documents, except if given to them through client.
* Will get notice of proceedings and decisions.
* Both allied person and legal representative or agent can attend.

*Formally appointed Guardians*

* No right of appearance – require leave
* Ad hoc notice of hearings
* But right to access documents under s 44 and s 76 of the GAA Act: Right to all information that the adult would have been entitled to if the adult had capacity and which is necessary to make an informed exercise of the power AND power to request health information from a health provider.

*Other support people*

* Depends upon the Tribunal sitting on the day.
* May allow 1 or 2 support people to come in, but they must remain quiet unless asked a question.
* Will not allow a cast of thousands and unlikely to allow if client already has lawyer and allied person in attendance.

*Who else is at the hearing?*

* MHRT panel
* Treating team: consultant, registrar, registered nurse, psychologist, OT, case manager
* Security guards
* Attorney-General’s representative

**Capacity**

Issue: Assessing a client’s capacity to give instructions, especially when they are deemed not to have capacity, by being placed on an ITO or forensic order.

*Capacity handbook and capacity training 18/06/14.*

Some basic points:

* Ethical duty to only take instructions from a person who has *capacity* to give those legal instructions.
* There is a presumption of capacity, including in the GAA (General Principle 1) and MHA s 8(b)
* Capacity is time specific, domain specific and decision-specific.
	+ ITOs mean that a person does not have capacity to consent to treatment for the illness, not necessarily that they do not have capacity to instruct.
	+ Capacity is not an issue in respect of FOs
* Capacity may be increased with appropriate support – time of day, after medications, after establishing a rapport, language
* Test we use under GAA:
	+ Understanding the nature and effect of decisions about the involuntary order
	+ Freely and voluntarily making decisions about the involuntary order
	+ Communicating decisions in some way.
* What this translates to is: Are they able to tell their story coherently? Are they able to understand what an ITO is and what would happen if they come off the ITO? Are they able to understand the MHRT process and what the MHRT can order?
* Very rarely do we have capacity issues.
* If capacity is a concern, can act on instructions of formally appointed guardian for legal matters or request MHRT to appoint as separate representative eg s 450(3).

What if client does not have capacity to understand the process before the MHRT? Who represents them then?

* No one. Unless someone is appointed as guardian or separate representative.
* It is not treating team’s role to advocate for the patient. Puts them in a really difficult position.
* MHRT can unilaterally appoint, but rarely do - $ issue

**Documentation, Evidence and experts**

What documents can I respect to receive:

ITOs:

* Notice of hearing
* Clinical report
* Notice of decision

FOs:

* Notice of hearing
* Forensic dossier
* Clinical report
* LCT review committee
* CFOS report
* Notice of decision.

Clinical reports:

* 7 days out from the hearing.
* Rarely received at this time. See stats on ppt
* Client may or may not receive copy
* May have to chase – through client, through MHRT or through MHA delegate at hospital.

Evidence and experts

* If putting in written subs / client statement – best to do before hearing to give MHRT opportunity to read
* Can put in own docs at time. May be letters of support, character references etc.
* Submission at hearing at own risk – depends on hearing member. Getting better.
* Calling witness? Again at own risk – best to notify tribunal and try to get their permission pre hearing, but even then may not work. Best for witness to come in person, easier to oust a witness if we have to call them.
* Alternative to witness: try and get MHRT to order a second opinion under s 190 or s 457.

**At the hearing**

* Under the Act, the Mental Health Review Tribunal is to exercise its jurisdiction in a way that is “*fair, just, economical, informal and timely*” (s 438). While still observing natural justice, hearings are to be conducted with as little formality and technicality as possible and the Tribunal is not bound by the rules of evidence (s 459).
* Initially legal representation was met with a fair amount of apprehension.
* Adversarial advocacy will be frowned upon. Depending on the outcome, will likely need to maintain a relationship between client and treating team.
* What do we do? Still let the client speak, then the treating team, we make sure everything has been said, highlight important issues and provide legal arguments.
* We will ask questions of the treating team. Important to be respectful, may have to ask “through” MHRT.

**Appeal process**

* Written reasons within 7 days - 21 days
* Appeal within 60 days.
* Form on courts website under MHC
* Appeal representation through LAQ.

**Forensic charges / forensic disability**

* Flowchart
* Forensic disability orders – same as forensic orders but where unsoundness of mind is connected to intellectual disability rather than mental illness.

**Other organisations**

* Do not hesitate to contact QAI for support
* Other organisations:
	+ LAQ – Advice and MHC matters
	+ Advocacy organisations: Amparo Advocacy, IAT, GC Advocacy, RIA, Sunshine Coast Citizen advocacy, SUFY, Mackay Advocacy, QPPD, Capricorn Citizen Advocacy
	+ Legal Advocacy: QADA, QPILCH, TAS

**Questions**

1. Terry Carney, Fleur Beaupert, Julia Perry and David Tait (2008). *Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-Dreams?* http://ssrn.com/abstract=1307346. [↑](#footnote-ref-1)