THE VALUE OF PROCEDURAL FAIRNESS IN MENTAL HEALTH REVIEW TRIBUNAL HEARINGS

Anina Johnson*

Imagine that, for some time, you have had a strange feeling that you are being watched. It is hard to put your finger on it. But you have a sense that some of the people that you pass in the street already know where you are going and what you are going to do. The TV presenters seem to be talking to you, and some of their comments seem to have a special meaning for you and your life. A few weeks ago, the correspondent on the evening news mentioned that financial markets were in meltdown and, the very next day, the ATM swallowed your card. You are sure that the news bulletin contained a warning especially for you.

At first, you were not too worried. But now the constant observation is starting to get sinister. You were sick the other week, and now you wonder if that might be because your food is being poisoned. So you stop eating unless you can see the packet of food being opened in front of you. Family meals with your parents have become tense, because you are not sure whose side they are on.

Eventually, your mother says that she will take you to your local hospital's emergency department to get some checks done. But, instead of doing blood tests, the young registrar talks to you about why you are worried about being poisoned and some of the other odd experiences you have been having. The next thing you know is that you are being admitted to the psychiatric unit of the hospital.

When you ask to leave, you are told that you are not allowed to go and that the hospital staff think you might have an illness called schizophrenia. But you are not mad. You do not hear voices. You do not see things that are not there. You are not a violent person. It is just that some odd things have been happening to you lately.

The Mental Health Review Tribunal of New South Wales

The Mental Health Review Tribunal of New South Wales (MHRT) makes orders which can have a significant impact on individual liberties. The MHRT can require that someone be detained in a mental health facility and receive compulsory mental health treatment, including (by special order) electro-convulsive therapy. It can order that someone living in the community be required to visit mental health professionals and take psychiatric medications.

The people who are potentially subject to the MHRT's orders are some of the most vulnerable participants in any court or tribunal process. They may still be experiencing symptoms of mental illness which are distressing and disorientating. They may be detained in confronting circumstances and with limited access to the internet or their own papers.

* *Anina Johnson is the Deputy President of the Mental Health Review Tribunal of New South Wales.* *This is an edited version of a paper presented at the Australian Institute of Administrative Law National Conference, Brisbane, Queensland, 21 July 2016.*

The case for their ongoing treatment is presented by professional staff who regularly appear before the MHRT. Yet the person who is potentially the subject of the MHRT's order rarely has the opportunity (or the financial means) to obtain an alternative 'expert' opinion. In about 20 per cent of cases, the person will not have access to a lawyer.

There are practical considerations too. The MHRT is a high-volume environment, with many matters on its list each day. As people wait for MHRT hearings, understandably, they can become stressed and agitated as the day goes on.[1] This increasing anxiety is likely to impact negatively on a person's ability to participate effectively in the MHRT hearing.

In New South Wales, the first hearing of the MHRT is usually conducted by a single legal member of the Tribunal (which reflects the fact that before 2010 it was the local magistrate who conducted these hearings). Subsequent hearings are conducted by a three-person panel, which comprises a lawyer, a psychiatrist and another suitably qualified person. The third member will have extensive experience in the area of mental health as a clinician, a carer for someone living with mental illness or a consumer of mental health treatment, or they may have a combination of these experiences.

The MHRT has a sound gender balance and includes people identifying as Aboriginal Australians as well as people from culturally and linguistically diverse backgrounds.

The values of procedural fairness

Much has been written about the purpose and value of procedural fairness. In his 2010 Sir Anthony Mason Lecture at the University of Melbourne, the Hon Robert French, Chief Justice of the High Court of Australia, said: 'Its origins and application raise an old-fashioned question: Is it about justice or is it about wisdom?'[2]

His Honour then posited several rationales for procedural fairness:

(1) That it is instrumental, that is to say, an aid to good decision-making.
(2) That it supports the rule of law by promoting public confidence in official decision-making.
(3) That it has a rhetorical or libertarian justification as a first principle of justice, a principle of constitutionalism.
(4) That it gives due respect to the dignity of individuals — the dignitarian rationale.
(5) By way of participatory or republican rationale — it is democracy's guarantee of the opportunity for all to play their part in the political process.[3]

Each of these justifications has a part to play in MHRT hearings. Being forcibly detained and required to receive psychiatric care is an imposition on a person's liberty and dignity. Whether those restraints are necessary should be decided by an independent, expert body. Public confidence in decisions of this nature demand that the hearing is fair and that the person whose liberty is at stake has the best opportunity possible to present their case.

Another way of thinking of the characteristics of procedural fairness in this context is by reference to the core values identified in the International Framework of Court Excellence: equality (before the law), fairness, impartiality, independence of decision-making, competence, integrity, transparency, accessibility, timeliness and certainty.[4]

As Richardson, Spencer and Wexler say, psychology and behavioural science show that the processes adopted by courts or tribunals are as important as their ultimate decision in driving satisfaction with the law and decisions made.[5] Procedural fairness for the MHRT is more than simply ensuring that particular administrative hurdles are jumped; it should lead the person who is the subject of the hearing to feel that they have been dealt with fairly.

Achieving procedural fairness in MHRT hearings

How does the MHRT work to achieve these lofty goals under the constraints of time pressures and resource limitations which are common to all tribunals?

Procedural fairness aligns with recovery

The primary focus of the hearing must be the person who potentially will be the subject of the MHRT's order. Allowing that person the opportunity to give their perspective on the evidence before the MHRT is key. It is vital that a person feels that they are an active participant and not merely an object which is being discussed.[6]

Carney et al aptly summed up the challenges in this area when they said:

> Consumers' ability to participate effectively in tribunal hearings depends on their capacity at the time, as well as their understanding of the tribunal's functions, their emotional state and the opportunity they are given to contribute.[7]

An important starting point is for one of the MHRT panellists (usually the lawyer) to explain in straightforward terms the purpose and procedure of the MHRT hearing. People should know what the MHRT's jurisdiction is and the criteria for exercising that jurisdiction. The MHRT will set out the order of events at a hearing so that the person concerned is reassured that they will have an opportunity to have their say and respond to anything said about them.

Some people who are detained in hospital involuntarily tell the MHRT that they accept that they are currently benefiting from hospital-based mental health treatment. However, they have concerns about the medication being prescribed, the ward in which they are detained or the fact that they have only limited leave. It is important to explain that the MHRT only has the power to make a decision that a person is detained in hospital (and the maximum length of that detention) or that they are discharged. The MHRT does not have jurisdiction over clinical issues.

Having said that, there is benefit in exploring other issues, even if they are outside the MHRT's jurisdiction. The MHRT offers an impartial and neutral environment in which these concerns can be raised, explored and heard. Ideally, of course, the same issues have also been explored with the treating clinicians. However, in a busy clinical world, there may not have been a chance to raise those issues or they may not have been listened to carefully. The MHRT hearing offers an opportunity to redress some of the power imbalances and to refocus the care being given to a person on their current and future concerns.

This approach is consistent with the principles of therapeutic jurisprudence in that it seeks to maximise the therapeutic consequences and minimise the anti-therapeutic consequences of the legal process.[8]

It is also consistent with recovery-oriented mental health practice. There are many definitions of what it means to adopt a 'recovery-oriented approach' to mental health care. The Australian Principles of Recovery Oriented Mental Health Practice state:

> ['Recovery' is] gaining and retaining hope, understanding of ones abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self.[9]

The Principles also include the following quote:

> It is important to remember that recovery is not synonymous with cure. Recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery — hope, healing, empowerment and connection — and external conditions that facilitate recovery — implementation of human rights, a positive culture of healing, and recovery-oriented services. (Jacobson and Greenley, 2001 p 482)[10]

The involvement of people in the development of their own recovery plans is now one of the general principles guiding care and treatment under the *Mental Health Act 2007* (NSW).[11] Allowing a person who is potentially being coerced into treatment the opportunity to talk about their hopes for the future in a public forum facilitates future conversations with treating clinicians, who will hopefully support those aspirations. It allows the person's own goals to be taken into account when prioritising the goals of treatment.

Involving people in their own hearings

Of course, some people in MHRT hearings struggle to express their views coherently. This may be because of ongoing symptoms of mental illness. The stress of the hearing itself can exacerbate existing experiences of mental illness so that people become overwhelmed.[12] If a person is hearing loud and distracting voices, it can be difficult to remain focused on what is said in MHRT hearings. Feelings of agitation and irritation can make it difficult for people to remain still and focused. Deep depression can take away the power of speech altogether.

Mental health medications and treatments can also significantly impact on a person's alertness and their ability to participate in a hearing. The MHRT is under a statutory obligation to enquire into this issue at all involuntary patient hearings.[13]

Where a person is struggling to express their views, the clinical input from the psychiatrist and other suitably qualified members of the MHRT is critical. My clinical colleagues have ways of asking questions which are simple, polite and focused and which are effective at assisting a person in mental distress to speak to the MHRT.[14] Sometimes it is simply a matter of giving a person the time to be able to gather their thoughts and respond. Patience is a crucial virtue.

This kind of engagement with a person is best achieved when the hearing is conducted face to face. About 50 per cent of the 17 000 annual hearings of the MHRT involve the members sitting across a table from the person concerned. These hearings take place across 36 mental health facilities in metropolitan and regional New South Wales. The immediacy of this face-to-face connection continues to be significantly better than a video connection, despite the improvement in video quality in recent years.

In 86 per cent of the MHRT's civil hearings, the person who was the subject of the hearing attended in person, by video or by phone. However, some hearings can and do proceed without the person present.[15] This is particularly the case where the application is for a renewal of a community treatment order. In those circumstances, the person is living in the community and is generally already receiving mental health care under a compulsory order from the MHRT. The MHRT will have written to the person to advise them of the hearing and expects their case manager to remind them of the hearing and encourage the person to attend. For a range of reasons, though, people may opt not to attend. However, the MHRT's usual practice is to attempt to contact the person by phone to allow them the opportunity of expressing their views if they wish to do so. People are often willing to be involved in a hearing if they are contacted in this way. This practice reinforces the MHRT's role as an independent arbiter and not a rubber stamp for clinical applications.

Of course, despite the MHRT's best efforts to explain its process clearly and to make that process as comfortable as possible, many people will still experience MHRT hearings as

distressing and anxiety provoking.[16] Access to legal representation offers another important way for a person's voice to be heard.

Legal representation before the MHRT is usually provided by Legal Aid NSW on a duty lawyer basis. A person can also engage a private legal representative. Representation was provided in 77 per cent of all hearings in the MHRT's civil jurisdiction.[17] The legal representatives before the MHRT will have had a private conference with the person concerned beforehand and had an opportunity to review their clinical file. Legal representatives are then able to convey their client's wishes to the MHRT, even if the client is too overwhelmed by the hearing to be able to communicate those concerns.

Sometimes the lawyer is able to suggest that particular friends or acquaintances might offer useful evidence. In addition, where reports canvass sensitive or traumatic issues, such as childhood trauma or recent experiences of acute mental ill health, the lawyer can indicate to the MHRT if there are any issues in dispute. This may mean that distressing matters do not need to be traversed publicly.

At the very least, a legal representative is an ally — a professional on the side of the person whose life is under scrutiny and whose presence helps to rebalance the inherent inequalities of appearing before the MHRT.

Public hearings

MHRT hearings are open to the public.[18] This is consistent with the principle of the open administration of justice, which allows for public and professional scrutiny of MHRT proceedings and offers a safeguard against abuse.[19] Sadly, the history of mental health care contains many stories of abuse,[20] making this safeguard an important one.

In practical terms, the MHRT almost never has general members of the public or 'court watchers' attend its hearings. The reasons for this are twofold. First, the MHRT does not provide any public lists of its hearings. Secondly, about 50 per cent of the MHRT's hearings are conducted inside mental health facilities.[21] The remaining 50 per cent of hearings are conducted by video link or phone from the MHRT's premises in suburban Sydney. As such, they are not readily accessible.

The lack of disinterested public observers is not inappropriate. The MHRT's proceedings are necessarily concerned with intensely personal matters relating to an individual's mental health, current living arrangements and personal background. There is no doubt that there is still a significant stigma attached to being diagnosed with a mental illness.[22] Sadly, this stigma is likely to be exacerbated if a person has been the subject of a compulsory order requiring them to accept mental health treatment. It is a stigma that can be felt keenly by the person concerned. [23] The *Mental Health Act 2007* (NSW) recognises this and makes it an offence to publicly identify by name anyone who has proceedings before the MHRT.[24]

However, the obligation to conduct public hearings does mean that family, friends and support people can attend an MHRT hearing if they wish and should not be excluded by the staff of the hospital where the hearing is held. It remains an important statutory protection.

Testing the evidence

Consistent with a therapeutic or recovery-based approach to its hearings, the MHRT adopts a courteous and respectful tone towards the person concerned, their family and the treating clinicians. Cross-examination of the person concerned in an attempt to elicit symptoms of mental illness is inappropriate.[25]

As in many tribunals, the rules of evidence do not apply to MHRT hearings. It is entitled to inform itself as it thinks fit.[26] Some of the evidence before the MHRT will be in the form of second-hand or third-hand hearsay. For example, evidence about what preceded an admission may be a brief report of a police officer who has decided to bring the person to a hospital. This report might be based on observations of people who raised the initial concerns about a person's conduct. The *Mental Health Act 2007* (NSW) also requires that a person be assessed at the hospital by two authorised personnel, one of whom must be a psychiatrist.[27] However, those observations are necessarily (and appropriately) coloured by the reports of what has occurred before they met an individual.

In the context of the relatively short MHRT hearing that is run largely on a duty list basis, it will rarely be possible to ascertain where the truth lies. But, if the MHRT is going to take into account that evidence, it is appropriate to offer the person concerned a chance to respond to the key points raised.

This can sometimes be a delicate process. People may not clearly remember the things they said and did at times of acute mental distress. Alternatively, it may be embarrassing to recall and discuss some of those experiences.

There are risks too with leaving alleged inaccuracies unchallenged. Reports of past behaviours can quickly be adopted as immutable facts and copied into each new report.[28] Past behaviours may be portrayed as ongoing issues rather than a historical matter.[29] By questioning the report writer about the source of their comments, the MHRT may reveal that the writer has added an unwarranted gloss to police reports or accepted hearsay reports as gospel truth. The MHRT file, if readily accessible, can be a useful way of trying to return to the original source material. If the file is not readily accessible, the MHRT can adjourn the hearing to allow for it to be obtained or make a note that it should be available if there is a subsequent hearing. If the report is found to be inaccurate, the MHRT can ask for a replacement report for its file, which should also have the effect of correcting the clinical record.

It may be unnecessary for the MHRT to make definitive findings of fact on issues of these kinds. Within an inpatient setting, with regular observations by experienced staff, clinicians are likely to be able to describe ongoing patterns of behaviour that indicate mental illness without requiring the MHRT to adjudicate on events that occurred many weeks (or months) before.

The MHRT needs to decide in each particular matter whether it is preferable to adopt a therapeutic approach (which may mean not attempting to untangle the hearsays of the past) or to try to reach a determination on the alleged inaccuracies in treating reports.

A variation on this difficulty occurs when those involved in the patient's day-to-day treatment are unavailable. The MHRT understands that the vagaries of hospital rosters and the vicissitudes of life mean that not all of the key players will be available for MHRT hearings. However, too often I have heard a person say: 'Listen, I only met this doctor this morning for 10 minutes. How does he know what I'm like?' When a person's liberty is at stake, it is important that the MHRT can question witnesses who are able to give careful, well-researched and considered evidence in relation to a person's current mental wellbeing and their likely future pathway with, and without, the proposed (compulsory) treatment.

Unless the relevant witnesses attend the MHRT's hearing, many of the considerable benefits of the MHRT's multidisciplinary panel are lost. Carney et al argue that the work of a mental health tribunal is necessarily embedded in a health and social context, which is why there is such value in members from those fields.[30] These members also add considerably to the

procedural fairness of MHRT hearings. As noted above, the person concerned is rarely in a position effectively to test the clinical evidence. The role of the clinicians on the MHRT panel is not to make a clinical judgment. But they can bring their clinical experience to bear on the evidence, test alternative treatment modalities and assess whether the evidence meets the statutory standards. This aids the MHRT's decision-making and provides the person concerned with a fairer hearing.

Finally, there is an important role that family and friends can play in the MHRT's hearings. The requirement to include family and friends in MHRT hearings was strengthened in recent amendments to the *Mental Health Act 2007* (NSW).[31] These amendments recognised that people close to a person are essential to supporting a person's recovery from illness and in discharge planning.[32]

The role of family and friends in a hearing can be a difficult one. Sometimes their support is welcomed. On other occasions, those closest to the person concerned are the most quickly attacked when that person's mental health deteriorates. Family and friends may also have been the instigators of the compulsory mental health treatment.

Family or friends should generally be invited to offer their thoughts at an MHRT hearing if they feel comfortable doing so. In my experience they often have valuable longitudinal information they can provide about the person's experiences of mental illness and recovery, which can significantly alter the trajectory of the decision-making process. Obtaining information of this kind is an important part of making a good and fair decision and, ultimately, maintaining trust in the MHRT's processes. However, it may also be seen by the person concerned as a betrayal. Pressure to provide information to the MHRT could fracture critical relationships.

Navigating this path is not easy. The MHRT has the option of conducting some or all of its proceedings in the absence of some of the parties to proceedings.[33] But taking the formal step of asking the person concerned to leave is likely only to increase that person's fears about what is being said in their absence.

Often a middle way can be achieved. The family may give subtle nods at comments made by the treating team before saying to the Tribunal, 'I have nothing I want to add'. The MHRT may be able to obtain some evidence by asking family members about the things that a person likes to do ordinarily (that is, when they are not unwell). Above all, the MHRT must not disrupt these important relationships by pressing for evidence unless it is critical to the MHRT's ultimate decision.

Fair decision-making

The vulnerability of people appearing before the MHRT, and the fact that many are already struggling with feelings of unease, distress or even paranoia, make it critical that the MHRT's processes *appear* fair. The transparency of the MHRT's processes is therefore a key factor in achieving a procedurally fair hearing. It is second only to ensuring that the person concerned has a proper opportunity to speak.

It is easy for the MHRT to be seen as a rubber stamp for clinical decision-making. A tiny proportion of the applications for involuntary treatment which were made to the MHRT in 2014–15 were refused.[34] However, it should not be presumed that the MHRT simply adopts, without question, the clinical team's recommendations. Carney et al suggest that an equally plausible explanation, and one I would endorse, is that clinical teams have already undertaken an internal triage in anticipation of the hearing and will only present those cases to the MHRT where they feel confident that their case is a strong one.[35] Certainly, my

experience is that, at any mental health facility, one or more people will have been discharged or given the option of remaining voluntarily in the 24 hours prior to an MHRT hearing.

The MHRT has other challenges to ensuring its processes continue to be transparent. Hearings take place in the same venues on a regular basis. The same panel members are likely to sit regularly at that venue. They will come to know the administrative staff and the treating clinicians, and have a certain familiarity with them. In addition, given professional contacts, it is possible that the lawyer appearing for the patient knows the legal member of the panel, or the treating psychiatrist may have worked closely with the MHRT's psychiatrist member. The MHRT must be diligent in ensuring that appropriate boundaries are maintained, not just in the hearing room itself but also anywhere on the grounds of the hospital.[36]

The final stage of any tribunal process is the decision-making process. Before reaching a decision it is important that the panel members take the time to discuss the matter privately amongst themselves. Only in rare cases will this will be unnecessary, and then only if the person concerned is not present or agrees to the MHRT's order.

At times, an adjournment may be necessary to ensure a fair decision.[37] In weighing up this issue, the MHRT bears in mind that an adjournment of an order detaining a person in hospital means that the person's legal detention remains on foot during the adjournment period.[38] In addition, the stress of Tribunal hearings for the person concerned, and their family, weighs against adjourning hearings unless it is essential to the fair determination of a matter.

The reasons, when finally delivered, need to convey the MHRT's decision without crushing the person or their hope for the future. The discussions amongst MHRT panel members before a decision is delivered can be used to help to craft the oral reasons for decision in a way that strikes an appropriate balance.

Formulaic repetitions of the statutory tests are not helpful. A brief summary of the key aspects of the evidence which have persuaded the MHRT to make the order should be included. It is appropriate that the MHRT acknowledge the person's own concerns so that they know that they were heard and understood, even if their view has not prevailed. Where possible, the MHRT can offer some praise for the person concerned and their steps towards recovery and some suggestion of optimism for the future.[39]

Conclusion

Serious mental illnesses can cause intense distress, as well as the disruption of the ordinary patterns of life. This distress can be compounded by being required to accept psychiatric treatment. The processes of the MHRT aim to offer a person in these circumstances the opportunity effectively to put forward their views about the need for compulsory mental health treatment. The MHRT hearing offers independent, expert, impartial scrutiny of these decisions and is the ultimate arbiter of whether compulsory treatment needs to continue. That in itself should offer reassurance to the person who is the subject of that decision.

Of course, we should not be too self-congratulatory. MHRT hearings will not alleviate the distress of mental illness. But the MHRT certainly endeavours not to make that distress more acute.

The power imbalances inherent in a Tribunal hearing mean that ensuring an impartial and transparent process is as important as the ultimate decision. The maxim that 'Not only must Justice be done; it must also be seen to be done' must be the MHRT's guidepost.

Endnotes

1 Terry Carney, David Tait, Julia Perry, Alikki Vernon and Fleur Beaupert, *Australian Mental Health Tribunals — Space for Fairness, Freedom, Protection and Treatment* (Themis Press, 2011) 172.
2 The Hon Robert S French, Chief Justice, High Court of Australia, 'Procedural Fairness — Indispensable to Justice?' (Sir Anthony Mason Lecture delivered at the University of Melbourne Law School, Law Students' Society, 7 October 2010).
3 Ibid 1.
4 International Consortium for Court Excellence, *International Framework for Court Excellence* (2014) <http://www.courtexcellence.com>. See also Elizabeth Richardson, Pauline Spencer and David Wexler, 'The International Framework for Court Excellence and Therapeutic Jurisprudence: Creating Excellent Courts and Enhancing Wellbeing' (2016) 25 *Journal of Judicial Administration* 148.
5 Richardson, Spencer and Wexler, above n 4, 159.
6 Carney et al, above n 1, 182.
7 Ibid 186.
8 Richardson, Spencer and Wexler, above n 4, 153.
9 Australian Government, 'Principles of Recovery Oriented Mental Health Practice', *National Standards for Health Services 2010* <https://www.health.gov.au/internet/main/publishing.nsf/Content/CFA833CB8C1AA178CA257BF0001E7520/$File/servpri.pdf>.
10 Ibid 42.
11 *Mental Health Act 2007* (NSW) s 68(h).
12 Carney et al, above n 1, 186.
13 *Mental Health Act 2007* (NSW) ss 35(2)(c), 38(2)(b), 64(2)(b), 96(6)(c).
14 See also Carney et al, above n 1, 102.
15 Mental Health Review Tribunal of New South Wales, *Annual Report 2014–2015*, 24.
16 Ian Freckleton, 'Mental Health Review Tribunal Decision-making: A Therapeutic Jurisprudence Lens' (2003) *Psychiatry, Psychology and Law* 10, 49.
17 Mental Health Review Tribunal of New South Wales, above n 15, 24.
18 *Mental Health Act 2007* (NSW) s 151(3).
19 See, for example, *Commissioner of the Australian Federal Police v Zhao* (2015) 316 ALR 378, [44] (French CJ, Hayne, Kiefel, Bell and Keane JJ); *Russell v Russell* (1976) 134 CLR 495, 520.
20 See, for example, New South Wales, Royal Commission on Callan Park Mental Hospital, *Report of the Hon Mr Justice McClemens Royal Commissioner Appointed to Inquire into Certain Matters Affecting Callan Park Mental Hospital* (1961). See also Australian Broadcasting Commission, Radio National, 'Behind the Ha-ha Walls' *Earshot*, 6 October 2015 (Stan Alchin) <http://www.abc.net.au/radionational/programs/earshot/behind-the-ha-ha-walls-mental-as/6807712>; Australian Broadcasting Commission, Radio National, 'Closing Gladesville' *Hindsight*, 5 October 2014 (Fred Kong and Janet Meagher) <http://www.abc.net.au/radionational/programs/hindsight>.
21 Mental Health Review Tribunal of New South Wales, above n 15, 21.
22 See, for example, Nicola Reavley and Anthony Jorm, 'Stigmatizing Attitudes Towards People With Mental Disorders: Findings From an Australian National Survey of Mental Health Literacy and Stigma' (2011) *Australian & New Zealand Journal of Psychiatry* 45, 1086.
23 Freckleton, above n 16, 48.
24 *Mental Health Act 2007* (NSW) s 162.
25 Freckleton, above n 16, 50.
26 *Mental Health Act 2007* (NSW) s 151.
27 *Mental Health Act 2007* (NSW) ss 27, 27A.
28 Freckleton, above n 16, 52–3.
29 Carney et al, above n 1, 213; Freckleton, above n 16, 51–2.
30 Carney et al, above n 1, 102.
31 *Mental Health Amendment (Statutory Review) Act 2014* (NSW).
32 New South Wales, *Parliamentary Debates*, Legislative Council, 18 November 2014, 2888 (John Ajaka, Minister for Disability Services).
33 *Mental Health Act 2007* (NSW) s 151(4).
34 In 2014–15, one per cent of patients at a mental health inquiry were discharged by the MHRT. At subsequent MHRT reviews of involuntary patients, 0.03 per cent of patients were discharged by the MHRT. The MHRT refused to make a Community Treatment Order in only 0.01 per cent of cases. See Mental Health Review Tribunal of New South Wales, above n 15.
35 Carney et al, above n 1, 91.
36 See also Freckleton, above n 16, 47.

37 Ibid 57.
38 *Mental Health Act 2007* (NSW) s 155(2).
39 A suggestion also made by Freckleton, above n 16, 59.