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**Providing legal representation to psychiatric patients under the Mental
Health (Compulsory Assessment and Treatment) Act 1992 (MHA
1992)**

*The experiences and perspectives of mental health lawyers who represent
clients under the MHA 1992*

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A thesis submitted in fulfilment of the requirements for the degree of Master of
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ABSTRACT

This thesis examines the role of the lawyers who represent clients under the Mental Health (Compulsory Assessment and Treatment) Act 1992. It focuses on their experiences and perspectives during the preparation and advocacy stages of mental health hearing and review processes. The study draws on data collected through semi-structured interviews with a small sample of Auckland and Waikato mental health lawyers (n = 11), and provides qualitative descriptions of how this role is executed in practice. The findings contribute to the limited existing research-based literature describing this role, as well as to understanding the barriers and enablers faced by lawyers in providing advocacy to patients in the mental health law context.

The study found that the mental health lawyer has a broader role than just protecting patients' rights. This role fulfils legal and some health and social functions, all of which were considered by the participants as important to effective legal representation. The participants protect their clients' rights to liberty by ensuring the accuracy of evidence presented by health professionals to justify compulsory treatment. In most situations, however, because their clients are acutely unwell, participants empower them in self-determination about their health and wellbeing and promote their leave, medication and treatment preferences to clinical and legal decision-makers. Participants' facilitation of their clients' contribution to their health-care and compulsory status decisions, at times, enabled clients to experience fairer hearings and advance their therapeutic goals. The study also found that participants experienced barriers to providing effective legal representation. Barriers included: limited ability to advocate for clients' health and social concerns, dependence on health professionals' interpretation of clients' mental health, communication difficulties with clients, inadequate training about psychiatric conditions, and health-dominated decision-making in legal processes. The thesis argues that these challenges might restrict the benefits of legal representation and perpetuate "best-interest" lawyering that favours clinical opinion over clients' circumstances and choices.

This thesis illustrates how the mental health lawyer can achieve accurate, fair and therapeutic outcomes for their clients in practice and identifies the factors which can limit this role from fulfilling its potential. These findings have significant implications for practising lawyers and the protection and promotion of mental health patients' rights.

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LIST OF ABBREVIATIONS

ADLS	Auckland District Law Society Committee
The Committee	ADLS Mental Health and Disability Law Committee
CompTO	Compulsory treatment order
CTO	Community treatment order
DI	District inspector
IPO	Inpatient order
MHA 1992	Mental Health (Compulsory Assessment and Treatment) Act 1992
MHT	Mental Health Tribunal
MHRB	Mental Health Review Board
MHRT	Mental Health Review Tribunal
PJ	Procedural justice
RC	Responsible clinician
TJ	Therapeutic jurisprudence

CHAPTER ONE: INTRODUCTION

Approximately one in every six New Zealanders will be diagnosed with a mental disorder at some stage during their lives (Mental Health Foundation, 2014). While most individuals voluntarily access help for their mental health concerns, in some situations psychiatric treatment can be compulsorily imposed on people. Section 2 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA 1992) gives the government the power to treat persons who meet the legal criteria of “mental disorder” without their consent (MHA, 1992). These criteria direct their admission to, and release from, compulsory assessment and treatment (Dawson, 2013). Section 2 states that a person must have an “abnormal state of mind,” and “pose a serious danger to the health and safety of that person or others,” or “seriously diminished capacity for self-care,” to be subject to the Act. In such situations, the liberty of the individual is at risk. Therefore, it is important that lawyers check the accuracy of clinicians’ and decision-makers’ application of the mental disorder criteria to their clients’¹ circumstances to ensure their loss of liberty is justified (Bell, 2005; Simpson, 1998). However, little is known about how the role of the mental health lawyer works, in practice.

To address this lack of knowledge, this thesis examines the role lawyers undertake as they represent clients in three mental health hearing and review processes: the section 16 review, the section 18 review and/or “defended” compulsory treatment order (CompTO) hearing, and the Mental Health Review Tribunal (MHRT) hearing (s 79), in practice. It also explores the challenges they are confronted with, as well as the positive aspects of providing legal representation in this context. This chapter outlines the rationale for this study by drawing on New Zealand policy and existing research in the field. It concludes by summarising the research aims, focus, and methodology, and providing an overview of the remaining chapters.

1.1 Rationale for Study

In New Zealand, inpatient and community-based compulsory care is the second greatest form of detention after imprisonment. Approximately 3000 to 4000 persons are subject to the MHA 1992 for being mentally disordered at any given time in a year (Dawson & Gledhill, 2013).

¹ The term *client* is used interchangeably with *patient*, *consumer* and *service user* to align with the terms used in the literature. Patient is the preferred term because it aligns with the MHA 1992. However, I sometimes used client when discussing the person in relation to their lawyer, as recommended by the ADLS (2010).

Latest statistics show that in 2014 the MHA 1992 was imposed on 9280 persons, and 5012 persons remained under the Act on the last day of the year (Ministry of Health, 2015). The proliferation in rates of compulsory community care is an international trend, evidenced by a recently published analysis of variabilities across 20 health districts in New Zealand and comparisons of these rates in international regions, including Australia (O'Brien, 2014). This research found that compulsory care rates have increased in New Zealand, with the average rates shifting from 58 per 100,000 in 2005 to 84 per 100,000 in 2011; international prevalence rates have also increased. In New Zealand, most patients are subject to compulsory community care (Ministry of Health, 2015). Additionally, Māori and individuals of low socioeconomic class are overrepresented in the mental health system, particularly in compulsory community care (Elder & Tapsell, 2013; O'Brien, 2013). Significant and disproportionate increases in compulsory community treatment raise questions about the fairness and adequacy of rights' protection provisions in place for mental health patients. This significantly impacts the role of the lawyer who plays a critical role in protecting clients' liberty rights and preventing illegal detention (Brookbanks, 2005b). Lawyers' observations of applying mental disorder criteria may illuminate reasons for increasing rates and address whether minority groups incur discriminatory practices.

The Ministry of Health administers the MHA 1992, aiming to uphold its competing objectives of protecting patients' liberty rights while ensuring their treatment needs and the public-safety interests of society are met (Ministry of Health, 2001, 2015). To ensure that there are adequate provisions in place to protect patients from breaches of their civil liberties, they are almost always afforded free legal representation, regardless of their socioeconomic status (Dunlop, 2013; Legal Services Act, 2011; Ministry of Justice, 2016a, 2016b). The New Zealand Law Society (2011) oversees the allocation of lawyers to patients who face legal processes through the administration of a legal aid funded Mental Health Roster, which is administered regionally in different ways (explained in more detail in Chapter 4). Lawyers advocate for their clients in mental health hearing and review processes to ensure that they are compulsorily treated only if they are mentally disordered, rather than for medical or other unlawful reasons (Brookbanks, 2005b). As described previously, this thesis is concerned with three legal processes: the section 16 Review, the section 18 Review and/ or a defended CompTO hearing; and the MHRT hearing (Ministry of Justice, 2011a) which are explained in more detail in Chapter 2. All three processes are inquisitorial, which in theory means that there is no "win-lose" situation, instead the courts or tribunals obtain information from relevant parties to find the truth (Brookbanks, 2005a).

However, Brookbanks argues that in practice the hearings contain a combination of adversarial and inquisitorial features. In order to maintain clients' civil liberties and the care and welfare purposes of the MHA 1992, he further suggests that lawyers adopt both adversarial techniques – for example, cross-examining medical evidence – and inquisitorial techniques – for example, being sensitive to patients' treatment needs, and promoting therapeutic relationships (Brookbanks, 2005a). However, little is known about the “effectiveness” of legal representation for the protection of patients' liberty rights and how lawyers represent their clients in these processes.

Although there are systematic provisions in place for patients' liberty rights protection, the MHA 1992 provides limited guidance on the mental health lawyer's role. Under section 70, patients are afforded the right to legal advice about their status and to be represented by a lawyer. Section 20 states that patients have the right to be heard in CompTO hearings “through a barrister or solicitor,” and that the lawyer may “call witnesses and cross-examine witnesses,” while, under sections 21, 22 and 23, the court accepts reports, evidence and witnesses respectively. While the Auckland District Law Society (ADLS) Mental Health and Disability Law Committee (the Committee) established Mental Health Roster guidelines (ADLS, 2010), which are “best-practice” guidelines for effective legal representation in the mental health law context (detailed in Chapter 2), little is known about lawyers' perceptions of their role and best-practice legal representation in this context. Therefore, their understandings are important to improve existing policy and guidelines related to their role.

Not only is empirical evidence about the adequacy of mental health lawyering in New Zealand scarce, but there is also little known internationally about the role and impact of lawyers on patients' likelihood of release from compulsory treatment. Under the former MHA 1969, patients did not have the right to legal representation; some authors claim this contributed to the inaccurate use of this legislation to manage and separate people who did not conform to social norms (Bell, 2003; Dawson, 1986). Quantitative studies, however, show mixed results on the impact of legal representation on patients' release from compulsory treatment (Blumenthal & Wesseley, 1994; O'Brien, Mellsop, McDonald, & Ruthe, 1995). Additionally, the latest available New Zealand statistics indicate that MHRT release rates are low; between 1993 and 2011 only seven percent of patients were discharged by the MHRT (Thom, 2014). Statistical findings do little in the way of highlighting the lawyer's role in legal processes, or the parameters of their achieving successful legal outcomes.

Mostly international research has touched on the role and impact of the mental health lawyer within explorations of mental health processes. A comprehensive literature review indicated that lawyers can increase the accuracy and fairness of decision-making (Thom & Nakarada-Kordic, 2014). Qualitative research reflecting tribunal members' perspectives on tribunal decision-making also show this finding (Peay, 1981; Perkins, 2003; Thom, Black, & Panther, 2015). Legal researchers have argued that vigorous lawyers can increase the “accuracy” of legal decision-making and strengthen the protection of their civil liberties (Freckelton, 2003; Morris, 2009; Pearson, 2004; Rogers, 1994; Sarkar & Adshead, 2005; Weller, 2011). Studies which have obtained patients' perspectives found that lawyers can positively and negatively impact their satisfaction with legal processes and wellbeing (Cascardi, Poythress, & Hall, 2000; Dolan, Gib, & Coorey, 1999; Ferencz, 2003; Greer, O'Ragan, & Traverso, 1996; Ng, Friedman, & Diesfeld, 2016). Despite this theoretical and empirical literature, lawyers' experiences and perspectives of representing clients are scarce (Beaupert, 2009; Campbell, 2008; Carney, Beaupert, Perry, & Tait, 2008). International findings are difficult to transfer to the New Zealand context due to procedural and jurisdictional differences. It is important to understand lawyers' perspectives on the kind of evidence they present and cross-examine and their potential impact on their clients and legal decision-making.

International and New Zealand literature and policy have suggested that lawyers might experience difficulties determining clients' “capacity to consent to treatment” or competence to make decisions for themselves (ADLS, 2010; Dawson & Szmukler, 2006; Morris, 2009; Perlin & Weinstein, 2016). These authors have argued that lawyers often have limited psychiatric knowledge, therefore they may rely on clinicians to inform understandings of capacity to consent which may have consequences for unjustified loss of liberty. There is also debate about the need for capacity criteria so that the MHA 1992 is only imposed on the individuals who demonstrate a lack of capacity to self-determination, as is the case for compulsory treatment for physical illness (Dawson & Szmukler, 2006; Skipworth, 2013). Knowledge about lawyers' engagement with capacity evidence and other challenges they experience in a medico-legal field are limited, warranting a need for more insight on this topic.

Overall, there is no research which specifically focuses on the experiences, perceptions and role of lawyers who advocate for clients in mental health hearing and review processes in New Zealand and endeavour to prevent abuses to their liberty rights. International empirical literature on this topic is also limited.

1.2 Aim of the Study

With these factors in mind, this study aims to explore and describe New Zealand mental health lawyers' experiences and perspectives of representing clients in the section 16 review, the section 18 review and/ or defended hearing and the MHRT hearing. It focuses on the practices that comprise the mental health lawyer's role, and the challenges and positive aspects of legal representation. The study's findings will contribute to existing knowledge on the lawyer's role, effective lawyering in the mental health law context, and the barriers and facilitators to effective legal representation. The findings may be of use to practising lawyers, policy makers and educationalists in law and mental health. It also has the potential to contribute to discussions on the ways to improve the quality of legal representation, including enhancing protections of patients' liberty rights and meeting their therapeutic needs.

1.3 Positionality of the Researcher

My background is in psychology and criminology. It is important to note, therefore, that this study was conducted through a social science lens, and does not intend to provide a legalistic analysis of the mental health lawyer's role. Legal literature and case law is discussed in this thesis, to clarify certain provisions of the legislation. My aim was to draw on my background, using a qualitative approach to explore the mental health lawyer's role from an outside perspective.

1.4 Research Methodology

This thesis used a qualitative methodology to generate rich, descriptive information, grounded in practising lawyers' perspectives (Sandelowski, 2000). A qualitative descriptive approach was optimal for this study because it aimed to explore lawyers' experiences and perspectives of the aspects of their practice which were going well and those in need of improvement. The research involved individual semi-structured interviews with 11 lawyers from Auckland and the Waikato. Further details on methodology and methods is outlined in Chapter 4.

1.5 Structure of the Thesis

Chapter 1 describes the rationale, aims and positionality of this study. Chapter 2 explains the processes that lawyers are involved with under the MHA 1992 and discusses information available within New Zealand about the mental health lawyer's role. Chapter 3 reviews and describes international and New Zealand theoretical and empirical literature on legal

representation in the mental health law context. Chapter 4 provides the reader with an understanding of the methodology, explains the chosen methods of data collection and analysis, and summarises the ethical issues and the approaches taken to ensure rigour. Chapters 5 and 6 present the study's findings. Chapter 5 outlines three themes on the role of the mental health lawyer, while Chapter 6 describes two themes on the barriers and facilitators to effective legal representation. Chapter 7 compares the study's findings to relevant literature and policy on this topic. It concludes with a summary of the study's strengths and limitations, and recommendations for future policy, practice and research.

CHAPTER TWO: BACKGROUND

Chapter 2 draws from legislation, New Zealand literature, relevant case law and policy to explain the role of the lawyer under the MHA 1992. The first section of this chapter briefly describes aspects of this legislation, including the mental disorder criteria and the mental health hearing and review processes, emphasising lawyers' involvement in these areas. The second section of this chapter describes and critiques best-practice guidelines for legal representation in the New Zealand mental health law context. The chapter aims to provide the reader with an understanding of the lawyer's role and the practices they undertake under the Act. It also highlights the challenges and dilemmas they might experience in protecting their clients' rights to liberty effectively in this context.

2.1 The Mental Health (Compulsory Assessment and Treatment) Act 1992

As mentioned in the previous chapter, the MHA 1992 defines the situations that permit persons to be subject to compulsory psychiatric assessment and treatment without their consent. The Ministry of Health (2012) guidelines explain that this legislation endeavours to balance individual rights with wider public-protection aims. Therefore, the role of the lawyer under the MHA 1992 is to assert patients' civil liberties and balance this with their need for treatment (Bell, 2005). Lawyers protect patients' rights to liberty under the Act in two ways: firstly, by applying the legal criteria *mental disorder* to patients' circumstances which directs their release or ongoing treatment under the Act and, secondly, by advocating for patients in mental health hearing and review processes. The sections below describe in more detail the mental disorder criteria which must be met for a person to be subject to compulsory assessment and treatment, and the mental health hearing and review processes in which lawyers advocate for their clients.

2.1.1 The mental disorder criteria.

The mental disorder criteria direct "entry into and exit from" compulsory assessment and treatment (Dawson, 2013, p. 29). Section 2 of the MHA 1992 states that a person must be mentally disordered to become subject to compulsory assessment and treatment; "mental disorder," it states,

in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it—

- (a) poses a serious danger to the health or safety of that person or of others; or

(b) seriously diminishes the capacity of that person to take care of himself or herself.

Lawyers apply the mental disorder criteria to their clients' circumstances to check that compulsory treatment is justified (Simpson, 1998). To be deemed mentally disordered, a person must meet both limbs of this definition. The first limb is "abnormal state of mind," and the second limb is "danger to health and safety of oneself or others," or a "diminished capacity of self-care." The person's abnormal state of mind must cause their dangerous or self-harming behaviour to justify the imposition of compulsory treatment (Bell, 2005; Dawson, 2013).

Inconsistencies in the application of the mental disorder criteria among lawyers, clinicians and tribunals may pose challenges for lawyers' ability to protect their clients' civil liberties (Simpson, 1998). Dawson (2013) has summarised three common approaches to interpretation of mental disorder: legal, psychiatric and dynamic approaches. The legal approach considers the purpose and function of the MHA 1992 and its consequences for individuals' situations and liberty. The psychiatric approach is "heavily dependent" (p. 30) on the clinician's assessment of mental disorder which direct the commencement and continuation of the Act for the patient. The dynamic approach is flexible, individualised and focuses on extra-legal factors pertinent to interpretations of the mental disorder criteria, including the strength of evidence and the consequences of release for the person. Dawson argues that judges, lawyers, clinicians and tribunals may interpret the mental disorder criteria through different worldviews. Various accepted interpretations of the criteria may compromise due process and patients' advocacy and rights protection, because lawyers might experience difficulties applying and challenging these criteria. The next sections detail how the two limbs that make up the definition of mental disorder are usually interpreted and applied, and discusses how these might impact on the lawyers' execution of their role.

2.1.1.1 First limb: Abnormal state of mind.

The Ministry of Health (2012) guidelines state that rather than "diagnosis" (p. 3), persons exhibiting, in excess, the following phenomena: mood, perception, cognition (thought) and volition (will power), have an "abnormal state of mind." The guidelines indicate that there are ambiguities in the interpretation of abnormal state of mind, particularly in relation to the thoughts and behaviours that constitute "abnormal." Psychiatric diagnostic categories do not automatically equate with abnormal state of mind, though these categories are usually used to inform the first limb of mental disorder (Bell, 2005; Rogers, 1994). The case, *Waitemata*

Health v Attorney-General (2005) exemplifies the attribution of abnormal state of mind to non-psychiatric categories. A pertinent question which arose in that case was whether RCH, the individual at the centre of the legal process, should be compulsorily assessed and treated. RCH had thoughts about harming women he felt they had done wrong to him, therefore had threatened to harm them. Although RCH did not suffer from a psychiatric illness, the court held that he had a disorder of cognition (s 2); his thoughts about harming women were sufficient to meet the statutory criteria for compulsory criteria.

The Ministry of Health (2012) guidelines describe that the “abnormal state of mind can be of a continuous or an intermittent nature” (p. 4). This allows the court or tribunals to consider extra-legal factors in their decision-making, such as insight, past behaviour, compliance to medication, and the likelihood of relapse, in determining patient discharge or ongoing compulsory care. For example, in *The Matter of T* [1993] 10 FRNZ 159, the MHRT held that T would not be discharged from the Act even though his mental health had improved and he was in remission, to prevent detriment to his mental health. There was reasonable medical evidence that the patient would relapse and risk posing a danger to himself, or others, without treatment and appropriate mental health management. The case exemplifies that even though patients may present well on the day of hearings, the fluctuating nature of their mental state may prevent discharge from compulsory treatment.

Overall, some of the accepted interpretations of the first limb of the mental disorder criteria, outlined in this section, may aid lawyers in their protection of clients’ rights, while others could adversely affect the execution of this role. Given that psychiatric diagnostic categories often inform the first limb of the mental disorder criteria, lawyers might experience difficulties applying it due to limited psychiatric knowledge and training compared to clinicians. The application of non-psychiatric categories and conditions of an intermittent nature as abnormal could decrease clarity about the conditions which constitute as abnormal. This unpredictability may negatively affect lawyers’ ability to argue against their client having an abnormal state of mind.

2.1.1.2 Second limb: Serious danger / diminished capacity to self-care.

To satisfy the second limb, persons must be a serious danger to the “health and safety of themselves or others” or have a “seriously diminished capacity for self-care” (MHA, 1992, s 2). Bell (2005) argues that the interpretation of the second limb is dependent upon numerous

extra-legal factors including how an abnormal state of mind is defined, the imminence of risk, past behaviour, acceptance of behaviour and adherence to treatment.

There is much controversy over the meaning of “danger.” Simpson (1998) has explained that danger must be imminent and demonstrable to justify the administration of compulsory care, and prevent persons from being detained solely due to mental illness (Simpson, 1998). In *The Matter of O* [1993] NZFLR 545, Judge Boshier found no evidence of a causal link between O’s abnormal state of mind and danger to health and safety of herself and others during a section 16 review. The judge deemed that while O had an abnormal state of mind under section 2, the second limb was not caused by the first limb, therefore, she did not meet the definition of mental disorder.

Among practitioners there is an ongoing debate about preference for a broad or narrow interpretation of “serious danger.” A broader interpretation is usually accepted by the courts and tribunals for public-protection purposes (Bell, 2005; Simpson, 1998). A broader definition encompasses physical harm, emotional and psychological harm. For example, in *The Matter of IC* [1996] NZFLR 562, the MHRT held that the patient IC met the serious danger criteria because he posed serious danger to the psychological health of others. However, section 4 of the MHA 1992 aims to safeguard against detention “on the grounds of political, religious or cultural beliefs, sexual preferences, criminal or delinquent behaviour, substance abuses and intellectual disability.”

“Diminished capacity for self-care” is interpreted as the lack of competency of the individual to take care of themselves. For example, persons with diabetes who are unable to take diabetic medication due to their mental condition meet sufficient grounds to be subject to the Act (Ministry of Health, 2012). Bell (2003) explains that incompetency for self-care is interpreted widely, encompassing an individual’s inability to manage in the wider community.

Overall, this section has shown that as with the first limb, common interpretations of the second limb (danger) of the mental disorder criteria can support or pose challenges for lawyers’ advocacy of their clients. A preference for broadly applying the second limb, and the ambiguities in its definition, could restrict lawyers’ ability to challenge their clients’ meeting the second limb criteria because a variety of behaviours may be interpreted as dangerous. This might result in the unnecessary detention of persons who exhibit thoughts and behaviours that differ from societal norms (Bell, 2005). In addition, the significance of extra-legal factors in

the application of the second limb could adversely affect lawyers' ability to challenge this evidence and maintain procedural due process.

2.1.2 Mental health hearing and review processes.

In mental health hearing and review processes, lawyers present useful information to courts and tribunals and present evidence to support their clients' cases (Simpson, 1998). Additionally, they check that the deprivation of their clients' liberty is justified. As mentioned in the previous chapter, this thesis is concerned with the section 16 Review, the section 18 review and/or the defended CompTO hearing and the MHRT hearing.

The three court and tribunal processes have many similarities but also important differences in jurisdiction and accepted procedures. The section 16 review is instigated by the patient usually during the assessment phases of the Act and involves an assessment of their condition by a Family or District Court Judge. After consultation with relevant stakeholders, including the responsible clinician (RC), at least one health professional and perhaps legal counsel, the judge determines if the patient is mentally disordered or not mentally disordered and "fit to be released" (s 2, MHA 1992).

The section 18 review is a mandatory legal process in which the patient's condition is reviewed, usually within 14 days after the RC has filed an application for a CompTO (s 14.4). As with the section 16 review, the judge will consult with relevant stakeholders to determine if the patient is mentally disordered or fit to be released. However, he or she will also determine whether an order is necessary (s 27.3). This results in either a community treatment order (CTO; s 29) or an inpatient order (IPO; s 30) being made, which typically lasts for six months (s 33). Three possible processes may occur within a section 18 review (s 50; ADLS, 2010). Firstly, if the lawyer argues that their client does not object to a CompTO and they can establish the client's competence to: make an informed choice, provide informed instructions (s 32.3, Ministry of Justice, 2011b) and communicate (s 40, ADLS, 2010), then, typically, they will request for the judge to immediately make an order. This kind of hearing is usually quick, approximately no longer than 15 minutes (Mackenzie & Shirlaw, 2002). Secondly, if a client objects to a CompTO and there are legal issues regarding meeting the first and second limbs of mental disorder, lawyers may request a defended hearing (s 50; ADLS, 2010; Mackenzie & Shirlaw, 2002). Thirdly, lawyers may request an adjournment to obtain a second medical opinion (s 21), or for extra time to prepare for a defended hearing (s 50; ADLS, 2010), as evidenced in *The Matter of H* [1994] 12 FRNZ 324.

The MHRT hearing involves lawyers representing clients who have applied for a review of their mental condition under section 79 because they are dissatisfied with the outcome of a mandatory clinical review (s 76). The MHRT can order the release of persons who are not restricted or special patients if it finds that they are “no longer mentally disordered” within the meaning of the MHA 1992 (s 2; Diesfeld, 2013; Dunlop, 2013; Thom, 2014). Although the MHRT does not have the authority to deal with issues such as the appropriateness of treatment (Diesfeld, 2013), it can make recommendations that changes be made to the patient's treatment regime (s 102).

Overall, in all the review processes the jurisdiction is narrow and limited to determining whether patients are mentally disordered or not mentally disordered. Additionally, the outcomes of these processes are limited to “release” or “ongoing treatment.” As outlined in the previous section, lawyers may face a number of challenges applying the first and second limb criteria to their clients’ circumstances. However, lawyers’ scope to advocate for clients is greater in the section 18 review or the defended hearing, which can include not only challenging the mental disorder criteria but also the need for an order, requesting an adjournment, and arguing for or against a CTO or IPO. One of the objectives of this thesis is to explore lawyers’ experiences of representing clients in these hearing and review processes.

2.2 The Mental Health Lawyer’s Role and Best-Practice Guidelines for Legal Representation

This section explores the policy that guides lawyers in their practice within the mental health law context. Some policies and guidelines specifically relate to the MHA 1992; others are broader.

External to the MHA 1992, there are some guidelines available for practising mental health lawyers. The “Mental Health Practice Standards” stipulated by the Ministry of Justice (2011b) and the Mental Health Roster guidelines developed by the Committee (ADLS, 2010) outline national best-practice guidelines for the legal representation of mental health patients. These standards and guidelines are explored in more detail below.

Both the practice standards and guidelines emphasise that lawyers must not act in clients’ best interests. Instead, they state that lawyers should represent clients’ instructions effectively, without disrupting the RC-patient relationship. The guidelines seek to direct lawyers’ practice under the Act and address the potential ethical and practical challenges they might experience

representing clients who are unwell, stressed and/or who experience difficulties instructing their lawyers and comprehending legal advice. These guidelines, however, can be vague and permit inconsistent practice because they lack specificity and clarity about the strategies lawyers should adopt while carrying out these procedures.

The Mental Health Roster guidelines outline how lawyers should relay clients' instructions that are of an extraordinary nature. They state that even though clients' instructions may seem unrealistic, unlikely to be successful, detrimental to their treatment and wellbeing, or contradictory to medical best-practice and legal advice, lawyers must act on clients' instruction and not in their best interests (ss 30-33). Section 30 asserts that lawyers must raise all issues experienced by clients in hearings.

There are some provisions in the Mental Health Roster guidelines that direct lawyers to understand clients' views and provide advice, even when they experience difficulties communicating with them. Section 36 states that lawyers should obtain clients' instructions and understand their concerns. Section 27 recommends that when clients cannot provide clear instructions, lawyers should consult with medical and health professionals and inform the court of uncertainties about their client's ability. Finally, section 32 and section 33.2 of the "Mental Health Practice Standards" maintain that lawyers should explain legal processes and advise clients about likely outcomes.

Both the "Mental Health Practice Standards" and the Mental Health Roster guidelines direct lawyers' interactions with medical and health professionals and, to a certain extent, how these collaborations can inform the strength of advocacy. They state that lawyers should liaise with medical and health professionals to understand their justification for an order and to seek adjournments (ADLS, 2010, s 34; Ministry of Justice, 2011b, s 34). They also advise that lawyers inspect paperwork, including clients' nursing notes, medical and case records, for information about clients' mental condition, consent, warning page – danger issues, treatment plan and discharge plan (ADLS, 2010, s 41; Ministry of Justice, 2011b, s 34.2).

The "Mental Health Practice Standards" contain certain rules that aim to clarify lawyers' practice when clients experience difficulties consenting to hearings or seemingly lack competence. Sections 32.3 and 32.4 of these standards suggest that when clients "lack competence to make an informed choice or give informed instructions", lawyers should presume competence "unless there are reasonable grounds for presuming that the client is not competent" due to mental illness or medication (Ministry of Justice, 2011b, p. 25).

Finally, more practical suggestions are provided by the Mental Health Roster guidelines. Section 52 of the guidelines states that lawyers should cross-examine evidence with clients' approval. Lawyers are advised to cross-examine the source and strength of evidence; history of illness; diagnosis, and whether it matches the first and second limbs of the definition of mental disorder; and clarify discharge plan, side-effects of medications, and the possibility and adequacy of the clients being treated in the community.

The "Mental Health Practice Standards" and Mental Health Roster guidelines are limited in several ways. Firstly, the guidelines do not provide lawyers with techniques to effectively advocate for clients whose instructions seem unrealistic. Secondly, they do not specify the techniques lawyers could adopt to work through clients' communication difficulties. Thirdly, the guidelines do not outline how much emphasis lawyers should place on discussions with medical and health professionals and medical records, to inform legal advocacy, or specify the situations in which it is appropriate to defer to them. Fourthly, there remain ambiguities in definitions of client "competence" and "informed consent, instructions and decisions." In addition, both the standards and guidelines are missing a clear test for capacity, nor do they define the behaviours and the situations that constitute incompetency and the meaning of "reasonable grounds" which justifies lawyers' assumptions that their clients lack competency. This lack of specificity may lead to inconsistent and subjective approaches to legal representation. Most importantly, they do not deal with the potential dilemmas lawyers may experience when advocating vigorously for clients who are ill and who would benefit from treatment. Finally, the guidelines do not detail cross-examination techniques that would be non-damaging to clients' therapeutic relationships, goals or professional reputations.

Overall, the best-practice guidelines lack specificity and important details on "how to practice" in this specialist field, particularly when lawyers face challenges sticking to their role of acting on clients' instructions and not in their best interests. Possible implications of the application of somewhat unspecific guidelines include confusion among lawyers on ways to practise, inconsistencies in the provision of legal representation and subjective problem-solving approaches to the challenges and dilemmas the guidelines seek to address. To further delineate these issues, this study aims to explore lawyers' experiences and perspectives of representing clients under the MHA 1992. Objectives include an identification of the ethical and practical challenges of representing mentally unwell people who are seemingly incompetent to make decisions.

2.3 Summary

This chapter provided the reader with important information about how the MHA 1992 works in practice and the role of the lawyer in this context. The information has included a description of New Zealand's mental health legislation and lawyers' involvement under it, particularly in relation to the legal criteria for compulsory assessment and treatment and the hearing and review processes. It has also described and discussed best-practice guidelines for effective legal representation. The next chapter presents a literature review on legal representation in the mental health law context, drawing from New Zealand and international literature.

CHAPTER THREE: LITERATURE REVIEW

This chapter reviews New Zealand and international literature on the lawyer's role, and legal representation, in the mental health law context. As discussed in the previous chapters, a significant number of individuals are detained and treated involuntarily each year, having been assessed as "mentally disordered" and assessed as "posing a danger to themselves or others." Consequently, mental health laws restrict the liberty of a substantial number of New Zealanders. In New Zealand, as in many countries, mental health patients have access to legal advice and legal representation when they are committed or wish to appeal their compulsory status. Legal representation may ensure that they receive advice on optimal choices, have their views heard in legal processes and are not detained illegally. The initial rationale of this literature review was to discover existing research-based knowledge about how the lawyer's advocacy role works in practice. Preliminary searches, however, indicated that there was limited research-based literature in this area. This chapter, therefore, takes a broader perspective by reviewing existing knowledge, including empirical studies and theoretical literature, on legal representation in the mental health law context.

The chapter is composed of two sections. The first section describes the method used to undertake this review; this includes the integrative literature review framework, search strategy, search outcomes and literature analysis method. Section 2 presents the findings from the review of the literature on lawyering in the mental health context. These are presented in themes and subthemes. The chapter concludes with a discussion of the gaps in the literature and an explanation of how this study will address them.

3.1 Section 1: Literature Review Method

3.1.1 Design.

An integrative literature review was conducted to explore existing knowledge on legal representation in the mental health law context in New Zealand and internationally. An integrative review is the broadest type of research review and provides a systematic framework to review both empirical and theoretical literature (Whittemore & Knafl, 2005). This chapter, therefore, includes non-research-based literature including book chapters, editorials and legal commentary. Although these sources are non-traditional for literature reviews, they were included due to the limited empirical research specifically exploring the lawyer's role and legal representation in the mental health law context, in practice. Additionally, a broader review

enables a holistic understanding of the chosen research topic and increases evidence-based practice.

3.1.2 Search strategy.

Fourteen electronic databases (AGIS Plus Text, EBSCOhost, Google Scholar, HeinOnline, JSTOR, Ovid MEDLINE, ProQuest Social Science Journals, PsycINFO, PubMed, Sage, ScienceDirect, Scopus, Taylor & Francis Online, Westlaw NZ) from several disciplines (law, medicine, psychology and sociology) were searched to identify relevant published sources on legal representation in the mental health law context. Several specialised books were also manually searched for relevant chapters; these included: *New Zealand's Mental Health Act in Practice*; *Non-Adversarial Justice*; *Law in a Therapeutic Key: Development in Therapeutic Jurisprudence*; and *Therapeutic Jurisprudence and Involuntary Commitment*. Published research-based and theoretical literature from 1992 to 2016 were searched. However, this review included some older sources due to limited recent publications on the topic and their relevance to this study. The titles and abstracts of all articles were read and included if the predetermined inclusion criteria were met (see Table 1). The sources that were excluded from this study were non-English sources, unpublished manuscripts, literature reviews and literature primarily about access to legal representation.

Table 1

Review Inclusion and Exclusion Criteria

Inclusion	Exclusion
English (New Zealand, international) sources	Non-English sources
Literature from 1992 onwards	Literature before 1992
Empirical research (incl. qualitative/quantitative/mixed methods)	Literature reviews
Opinion sources (For example, book chapters, editorials, legal commentary)	Unpublished manuscripts (theses, dissertations)
Primary focus legal representation in the mental health law context	Primary focus access or availability of legal representation

A combination of search terms was used in this search. Table 2 presents the variations of each of the terms used: “patient rights,” “legal representation,” “compulsory treatment,” and “hearings.”

Table 2

Search Terms

Patient rights	Legal representation/ representative	Compulsory treatment	Hearings
Human rights	Lawyer	Involuntary commitment	Mental Health (Review) Tribunal
Civil rights	Legal advice	Mental health legislation	Mental health (judicial) hearing/s
Psychiatric patient rights	Advocacy	Psychiatric commitment	Review process
Client rights	Legal counsel		Legal proceedings

3.1.3 Search outcomes.

The initial search yielded 1,600 articles, and 211 articles met the inclusion criteria after an initial screening. The article and chapter titles, and abstracts, were further surveyed, and the sources which cited “lawyer,” “legal representation,” “advocacy,” “counsel,” “tribunal,” “legal processes,” or “hearing” (n = 93) were included. To prevent relevant literature from being excluded, the above terms were also electronically and manually searched for, in each source. The inclusion and exclusion criteria were further applied to articles and chapters to ensure inclusion of relevant literature only. Citations included in relevant sources were also checked for their possible inclusion.

In total, 50 sources met all inclusion criteria. There were 19 legal commentaries, six editorials or book chapters and 25 articles reporting findings of research studies: three quantitative, 14 qualitative, and eight mixed-methods studies. Included sources were from various countries including the United States of America (n = 20), the United Kingdom (n = 6), Australia (n = 15), and New Zealand (n = 9). The majority were non-research-based literature (legal commentary, editorials and book chapters; n = 25) and most studies employed qualitative methodology (n = 14).

3.1.4 Literature analysis.

Firstly, a reading of all sources took place and initial ideas about legal representation were noted. Secondly, data extracts related to the search terms were highlighted and coded; the extracts that were extracted and summarised included information on the lawyer’s role, and potential role, in the mental health law context, and challenges to effective legal representation. Thirdly, similar codes and extracts were placed into categories. Next, all categories were

displayed and compared. The last step was the creation of themes consisting of similar codes across all sources.

3.2 Section 2: Findings

Section 2 reviews the literature on legal representation in the mental health law context. The review identified three themes. The first theme addresses literature on the contested nature of the lawyer's role. This has two subthemes: i) best-interest versus adversarial lawyering, and ii) finding a middle ground. The second theme describes literature on the positive impacts of contemporary approaches to lawyering in mental health contexts. The third theme reviews the literature on the challenges and dilemmas lawyers continue to face in the contemporary mental health law context. The third theme is comprised of four subthemes: i) preparation and instructions, ii) medical dominance, iii) prevailing sanist attitudes within the mental health system, and iv) training for the mental health lawyer role.

3.2.1 Theme 1: Contested approaches to legal representation in the mental health law context.

This theme presents historical and contemporary conceptualisations of the role of the lawyer and best-practice legal representation in the mental health law context. Historically, the debate has focused on whether the best-interest or adversarial approach is the optimal approach to lawyering. The contemporary focus has signalled a move away from the simplistic and dichotomous debate of best-interest versus adversarial approaches, often attempting to find a middle ground to work from. Therefore, this theme comprises of two subthemes: i) adversarial versus best-interest approaches, and ii) finding a middle ground.

3.2.1.1 Adversarial versus best-interest approaches.

The literature reviewed suggested there has been debate for some time around the best approach to lawyering in the mental health law context. Historically, the focus has been on whether lawyers should zealously represent clients' instructions or act in their best health interests. This subtheme, therefore, provides a brief historical overview to lawyering in the mental health law context, drawing from the work of a number of authors who have outlined historical backgrounds to this role.

Cook (2000) argued that prior to the 1960s and 1970s, legal representatives undertook a best-interest and paternalistic approach to lawyering. Cook claimed that this approach involved lawyers abandoning their traditional adversarial role and performing perfunctorily, by mostly

deferring to medical opinion and rarely acting upon clients' instructions. Abisch (1995) provided an explanation for the rationale for lawyers adopting a best-interest approach. She postulated that lawyers may have been reluctant to challenge involuntary commitment due to the belief that hospitalisation was in their clients' best interests. Other authors agreed that this meant lawyers did not zealously advocate for clients, rarely called on witnesses or cross-examined health professionals, and inadequately prepared for hearings or investigated clients' circumstances (Abisch, 1995; Perlin, 1992). The authors claimed that because lawyers adopted a best-interest approach, civil commitment hearings were merely formalities that did not adequately protect patients' liberty rights (Cohen, 1996). Additionally, Andalman and Chambers (1974) claimed that the lawyer's role as protectors of patients' rights in legal processes were misaligned because their actions were contradictory to rights protections.

Cook (2000) posited that the civil rights movement of the 1960s and 1970s contributed to a change from best-interest to adversarial lawyering. He explained that, during this time, deinstitutionalisation of psychiatric hospitals was underway and societal attitudes towards mental institutes were largely negative and sceptical. Several authors argued that lawyers believed adversarial confrontation would be an effective approach for truth-seeking that would prevent the unnecessary detention of individuals in psychiatric institutions (Appelbaum, 1983; Daicoff, 2006). Abisch (1995) claimed that contrary to best-interest approaches, lawyers who adopted an adversarial role advocated for clients' release, sought expert opinions, probed witnesses for facts and sought alternative explanations for clients' behaviour.

Contemporary legal scholars have conveyed that both styles of legal representation had limitations for the protection of patients' liberty and treatment rights. They suggested that the best-interest model relied heavily on the discretion of psychiatrists, resulting in patients being unjustifiably detained for extensive periods of time without adequate treatment for their mental condition (Wexler, 1992; Winick, 2003). Conversely, other researchers argued that adversarial lawyering and zealous advocacy did not adequately meet psychiatric patients' treatment needs (Cook, 2000; Winick, 2003). They suggested that although a larger number of patients were released from involuntary commitment, many then became incarcerated under the criminal justice system, for delinquent behaviour, or suffered homelessness; criminality and homelessness may have also resulted from the deinstitutionalisation of hospitals. Abisch (1995) postulated that adversarial techniques may have also been distressing for clients and disrupted their relationship with clinicians.

The literature reviewed also identified several benefits of both best-interest and adversarial advocacy. Legal scholars indicated that the best-interest model had significant benefits for patients' treatment (Appelbaum, 1983), while the adversarial model supported the protection of psychiatric patients' liberty rights (Winick, 2003). Several academics promoted a best-interest approach, suggesting that patients' desire to be released might have been influenced by their mental condition (Appelbaum, 1983; Brakel, 1981). Brakel argued that it was more appropriate for mental health lawyers to act as counsellors or mediators, to determine the course of action in clients' best health interests, than to fight for their release. Conversely, Winick (2003) claimed that zealous lawyers enabled clients to be heard and ensured fairer legal processes overall. He suggested that a fairer process may have had certain therapeutic benefits for their holistic wellbeing.

It is evident that, historically, there has been dissent about the mental health lawyer's role and whether a best-interest or adversarial approach to lawyering is more effective in this context. Some academics indicated that lawyers faced challenges determining the optimal model of legal advocacy, and how to protect clients' legal rights and best meet their clinical needs. Additionally, within the body of scholarship, there was a discussion about the benefits of both approaches that, by themselves, did not adequately protect clients' liberty rights and achieve positive health outcomes for them.

3.2.1.2 Finding a middle ground.

Contemporary literature on the mental health lawyer's role has attempted to move away from best-interest and adversarial approaches to provide theoretical and practical guides that allow for a middle ground. Several academics have developed alternative approaches to best-practice legal representation in the mental health law context. This subtheme describes the literature on these newer approaches.²

In the 1990s, alternative approaches to lawyering in the mental health law context emerged in response to dissatisfaction with predominant lawyering approaches to protecting patients' rights or promoting their needs (Freckelton, 2003). Daicoff (2006) called this wider movement the "comprehensive law movement," which can be characterised by a non-adversarial approach to lawyering that is explicitly more "comprehensive, humanistic, interdisciplinary and

² The theorists' recommendations do not necessarily align with the different vectors described in this section. Instead, they generically guide mental health lawyers' practice.

therapeutic” than adversarial models (p. 1). The inquisitorial approach of many mental health law proceedings was seen to have contributed to role confusion (Perlin & Lynch, 2016; Rogers, 1994). Perlin and Lynch (2016) argue that inquisitorial settings may create “rolelessness,” encouraging lawyers to revert to acting in what they perceive is clients’ best interests when they are uncertain about whether clients’ liberty or treatment needs are more pressing (p. 304). This role ambiguity may also be faced by New Zealand lawyers, as explained by Rogers (1994). She contends that inquisitorial processes may imply to lawyers that their role is to collaborate with judges and clinicians on a decision that is in clients’ best health interests, therefore undermining clients’ ability to determine their own best interest (Rogers, 1994).

Dissatisfaction and confusion with the lawyer’s role is debated in many areas of law, particularly in relation to the negative impacts legal practitioners, and the law itself has on clients (King, Freiberg, Batagol, & Hyams, 2009). Daicoff (2006) surmises alternative approaches to legal representation under the comprehensive law movement. These approaches aim to show lawyers how they may protect patients’ rights and achieve therapeutic outcomes for them. This movement recognised the negative emotional and psychological impacts on individuals of the adversarial legal system, and aimed to reduce the anti-therapeutic consequences of legal processes using non-traditional methods. Daicoff explains that the comprehensive law movement is composed of nine vectors, including “collaborative law, creative problem solving, holistic justice, preventative law, problem solving courts, procedural justice, restorative justice, TJ and transformative mediation” (pp. 1-2).

Several legal commentaries expand on the vectors described by Daicoff (2006), aiming to guide lawyers to reach a middle ground suited to clients’ circumstances. In particular, procedural justice (PJ; Tyler, 1992); mediational lawyering (Abisch, 1995); and therapeutic jurisprudence (TJ; Wexler, 1992; Winick, 1999, 2003) are vectors that were explicitly discussed in relation to the mental health law context by authors included in this review. These three vectors aim to protect patients’ legal rights and facilitate positive outcomes for individuals facing legal processes. However, they sometimes differ, to a degree, in recommended applications of the law and legal practice.

Procedural justice theory suggests that persons are more concerned with procedural due process than the legal outcome of proceedings, (Tyler, 1992). Tyler describes “subjective neutrality,” (p. 439) a three-component concept comprising participation, dignity and trust, claiming that these are important to individuals’ perceptions of procedural fairness. Tyler states that

participation means the individuals feel that they have had adequate presentation of evidence and opinions and have contributed to judicial decision-making. Dignity refers to the perception by individuals that they were treated with respect by authority, including lawyers. Trust relates to individuals feeling that authority is concerned about their wellbeing, that they have been supported in participating in legal processes and respected by those in authority. Winick (1999) postulates that these perceptions of fairness can have positive therapeutic consequences for individuals under mental health legislation processes, including satisfaction with legal processes and increased compliance with treatment.

Mediation lawyering has been described in the literature as involving lawyers working with clients to address their treatment and social concerns to support long-term therapeutic goals (Abisch, 1999). Abisch contends that mediational lawyers work through legal issues, and miscommunications and misunderstandings between clients, treatment teams and judges, thereby improving each party's understanding of the concerns and needs among them.

Therapeutic jurisprudence in the mental health law context is concerned about the effect of the law on the psychological wellbeing of patients (Winick, 1999). It seeks to minimise the anti-therapeutic consequences of substantive "legal rules, legal procedures and legal actors" (lawyers) and maximise its therapeutic potential for patients without subsiding due-process principles (Wexler, 1997, p. 233). Knowledge about the impact of "psycho-legal soft spots," (p. 333) including legal issues and procedures, on clients, allows lawyers to adjust practice to lessen negative emotions and enhance wellbeing (Wexler, 1998).

The vectors draw from different disciplines including psychology, sociology and the law; however, they share the common goals of the comprehensive law movement. This movement aims to protect patients' legal rights and achieve "optimal human functioning" (Daicoff, 2006, p. 4) for persons who are subject to legal proceedings in two ways. Firstly, lawyers should see the law as an agent that may facilitate "positive interpersonal and individual change" (p. 4). Lawyers should shape their practice around an "ethic of care," meaning that they have the duty to practice in a manner that maximises "the emotional and psychological well-being of clients" (p. 4). Secondly, lawyers should look at legal rules, as well as "extra-legal" factors. It is important that lawyers consider the consequences of legal processes on extra-legal factors including "values, beliefs, needs, psychological matters, personal wellbeing, human development, growth and interpersonal relations" (p. 4). Building on this argument, Weller

(2011) recommends that lawyers understand the therapeutic and relational potential of the law and change advocacy practices to enhance clients' therapeutic needs and relationships.

Not only do alternative (comprehensive) approaches to legal representation value positive outcomes, they also equally value adequate protection of individuals' rights by maintaining the rule of the law and due process (Daicoff, 2006). Winick (1999) contends that effective mental health lawyers maintain procedural due process by ensuring clients' viewpoints are heard, presenting evidence in favour of clients' cases, cross-examining opposing evidence and clarifying the basis for compulsion. Similarly, Sarkar and Adshead (2005) argue that lawyers should cross-examine psychiatrists to improve the quality of the evidence upon which compulsion is justified and to ensure the evidence accurately reflects their clients' current situation rather than the likely risk they pose. According to Freckelton (2003), sensitive, open-ended and non-badgering cross-examination increases rigour by putting forward the patient's information, while simultaneously avoiding patient distress or embarrassment, or disrupting relationships with their psychiatrists. Pearson (2004) and Weller (2011) recommend that lawyers incorporate clients' perspectives and "empower and encourage" (p. 86) them to self-determination so that their treatment needs and wishes shape the treatment they receive. Perlin and Weinstein (2016) promote a "supported decision-making" model of legal representation, contending that lawyers should support clients to exercise their legal capacity by understanding their clients' objectives, informing them of their possible choices and enabling them to make legal decisions for themselves based on their circumstances. Bisogni (2002), however, argues that mental health lawyers have a "delicate duty" (p. 74) to balance clients' liberty rights and treatment needs. For example, when clients are unwell, they should reduce cross-examination and present honest information to the tribunal to support treatment needs.

Theme 1 synthesised the literature on the discourses surrounding the lawyer's role in the mental health law context. Firstly, it provided a historical overview of best-interest and adversarial approaches to lawyering. Secondly, it discussed contemporary alternative approaches to lawyering that aim to balance advocacy suited to clients' circumstances and needs. It described the comprehensive law movement, and three vectors (PJ, mediational lawyering and TJ). Furthermore, it highlighted several academics' recommendations about how lawyers can reach a middle-ground by promoting clients' civil liberties without disrupting their therapeutic goals.

3.2.2 Theme 2: The positive impact of mental health lawyering.

Theme 2 outlines the available theoretical and empirical literature on the impact of mental health lawyering in practice, with a particular focus on how lawyers can facilitate positive outcomes for clients. The literature reviewed discovered that lawyers facilitate positive outcomes by maintaining procedural due process and engaging with clients, and other stakeholders, involved in compulsory treatment processes. The positive ramifications include assisting court and tribunal decision-making, enhancing clients' perceptions of fair hearings and enabling clients access to better quality health care.

Some sources suggest that lawyers assist accurate and fair tribunal decision-making by revealing weaknesses in the evidence considered by the tribunal. The sources demonstrate that challenging evidence helps tribunals to effectively balance individual rights and public-protection interests. Coates (2004) claims that legal representation of both the detaining authorities and patients before the United Kingdom MHRT would ensure presentation of robust evidence to the tribunal. Thom et al.'s (2015) research demonstrates how lawyers enhance accurate and fair decision-making. The study aimed to investigate the New Zealand MHRT's decision-making through interviews with tribunal members (n = 14), hearing observations (n = 11), and written decision reviews (n = 60). Tribunal members observed lawyers challenging clinicians on the quality and relevance of the evidence justifying clients' need for compulsion that was presented to the tribunal.

Other studies demonstrate that lawyers enhance their clients' perceptions of the fairness of tribunal decision-making by asserting their evidence to the tribunal or supporting them to participate in legal processes. Swain (2000) conducted a study to investigate the practical and fairness dilemmas experienced by the Mental Health Review Board (MHRB) in Victoria, Australia in balancing informality with due-process rights during hearings. Observations of 25 Mental Health Tribunal (MHT) hearings across six psychiatric facilities revealed that clients were represented in only two hearings. He argues that lawyers can support clients to participate in and be heard by the tribunal. Similarly, in Thom et al.'s (2015) study, observations of hearings revealed that in four hearings lawyers discussed clients' views about meeting the second limb (danger) of the mental disorder criteria during opening submissions of MHRT hearings. One United Kingdom, mixed-methods study suggests that lawyers' assertion of clients' evidence increases the fairness of hearings because it lowers the power imbalance between client and the tribunal panel (Ferencz, 2003). Interviews with patients (n = 17) and

tribunal members (n = 10) were conducted to investigate their experiences and concerns about MHRT proceedings. Patients described feeling unheard by tribunal members and indicated that there was limited interaction between them and the tribunal panel. Conversely, tribunal members believed that they had listened to the patients. Ferencz recommends that lawyers may decrease patients' feelings of powerlessness during hearings by promoting their views to the tribunal.

Research shows that lawyers only enhance patients' perceptions of fair tribunal hearings when their roles are performed accurately. An article by Carney, Tait, Chappell, and Beaupert (2007) aimed to clarify the meaning of several socio-legal concepts including *fairness* and *therapeutic outcome* by assessing different practices in tribunal processes. This article reports on one aspect of findings from a large study on MHTs. Data was collected in three Australian jurisdictions (VIC, NSW and ACT) through interviews with clients (n = 120) and various stakeholders (n = 30), hearing observations (n = 100), focus groups (n = 5) and client case and written records (n = 10,000). Findings revealed that for patients to perceive hearings as fair, lawyers should facilitate an interactive conversation between patient, tribunal member and clinician rather than a discussion about the patient that excludes their participation.

The empowerment of clients to understand and exercise legal rights is another potential positive outcome of legal representation, some sources indicate. A United Kingdom, qualitative study found that some lawyers clarified their clients' understanding of legal rights and tribunal processes (Dolan, Gibb, & Coorey, 1999). Seventy patients were interviewed to investigate their experiences of tribunal processes and legal representation. Out of 56% patients who believed that their legal rights were explained to them accurately, 12% stated that their lawyers had clarified their rights to them. Similarly, a New Zealand qualitative study by Ng et al. (2016), that aimed to examine patients' perspectives of applying to the MHRT and of being subject to the MHA 1992, found that lawyers had a similar role. Out of the 10 forensic mental health patients interviewed, two of them stated that their lawyers had advised them to withdraw applications to the MHRT due to there being little chance of release.

Several (n = 3) sources suggest that another positive consequence of legal representation is the empowerment of clients to manage their health. Du Fresne (1996, 2003) contends that lawyers who maintain procedural due process (for example, adversarial techniques and promoting views) enhance patients' perception of fairness and satisfaction with hearings, therefore empowering them to manage their wellbeing. A New Zealand study by Diesfeld and McKenna

(2007) also found the lawyers can support clinical goals in this way if they correctly apply TJ principles and understand the potential of their role. Ninety-five cases were analysed to investigate the unintended consequences of the pro-therapeutic intentions of advocacy and application of TJ in MHRT proceedings. Findings revealed that some lawyers adopt TJ principles uncritically, therefore providing indifferent advocacy and not maintaining procedural due process (for example, not making closing submissions or proposing alternatives to inpatient treatment). Diesfeld and McKenna argue that this may have had anti-therapeutic consequences on the patients at the centre of legal processes. They recommend that lawyers apply TJ principles precisely so that their clients may experience fair hearings and reap the long-term therapeutic consequences (described above) of experiencing fair procedure and being heard.

Some research from the United States, however, found inconclusive evidence about lawyers' potential to empower clients to comply with treatment. Two studies found different levels of associations between components of PJ theory (being heard, trusting authority and satisfaction with legal processes) and patients' perceptions of fairness, and medication-compliance behaviours, in practice. A qualitative study by Greer et al. (1996) administered a questionnaire that assessed the levels of trust, fairness and satisfaction of nine patients. Although a majority of the participants ($n = 7$) trusted and felt respected by their lawyers, most ($n = 8$) reported that their lawyers were disinterested in their stories and that they felt dissatisfied with the legal process overall. A quantitative study by Cascardi, Poythress, and Hall (2000) found different links between perceptions of fairness and compliance with treatment. The study aimed to test the impact of lawyers' maintenance of due process on patients. It analysed 40 adult patients' ratings of a mock video trial which used positive procedural justice (PPJ) and negative procedural justice (NPJ). In the PPJ trial, the patient's involvement in the hearing was supported and the person was treated respectfully. Conversely, in the NPJ trial, the patient's involvement in the hearing was not supported and the person was not treated with respect. The participants rated different components of the trial video including their perceptions about how fair and satisfying the hearing was, whether they felt the authoritative figure had been respectful, whether they felt the patient in the video was given a voice, the impact (positive or negative) of the hearings on the patient in the video and participants' attitudes towards hospitalisation, treatment and medication. Analysis of participants' self-reported information revealed their belief that the patient in the PPJ video had received good legal representation, was given a voice, treated respectfully and had a fairer hearing (positive emotional impact = t

(38)= -5.28, $p < .01$). It also found some links between positive emotional impact and predicted compliance with hospitalisation (expected positive therapeutic impact in psychiatric hospital = $t(38) = -3.10, p < .05$).

Several Australian sources suggest that lawyers enable clients' access to better quality treatment by actively collaborating with various stakeholders involved in involuntary commitment processes and facilitating dialogue among them. Beaupert's (2009) study examined the meaning of advocacy, the adequacy of legal representation in MHT processes and its contribution to tribunal decision-making. The study reports on data collected through interviews and informal discussions with two legal advocates, two hearing respondents and observations of hearings. Beaupert contends that good lawyers can effectuate several positive health and life outcomes for clients by mediating conflicts and miscommunications between client and doctor, and client and family, and addressing treatment and social concerns. For example, lawyers negotiate clients' desires to be treated in the community, and pay their own bills, and advocate for changes in clients' treatment plans. Other Australian articles posit that lawyers can promote therapeutic goals by facilitating interactive discussions between clients, tribunals and psychiatrists (Carney, Beaupert, et al., 2008; Carney & Tait, 2011; Carney, Tait, & Beaupert, 2008). Currently, Australian MHTs have limited power to address patients' health and life needs, and their jurisdiction is limited to determining whether the person is mentally ill, needs to be under compulsory treatment and whether there is no other less restrictive treatment option for them (Beaupert, 2007). Despite the narrow jurisdictional boundaries of MHTs, lawyers can ensure clients' complaints are heard by clinical decision-makers (Carney, Beaupert, et al., 2008). Carney, Tait, and Beaupert's (2008) study found that there are benefits to lawyers' relaying clients' grievances to tribunals as it may push them to facilitate indirect changes in clients' treatment and discharge plans. For example, the study provides an example of how lawyers' portrayal of clients' desires to be treated close to home, or be released, resulted in tribunals recommending community treatment or an early clinical review to the clinical teams.

Theme 2 summarised the literature on the positive impact of mental health lawyers in practice. The evidence revealed that lawyers can facilitate positive outcomes for their clients. Firstly, they can challenge the quality of the evidence supporting their clients' compulsion and assert clients' rights and views, to support tribunals to achieve an accurate and fairer balance between individual rights and public-protection aims. Secondly, they may empower clients to exercise their rights by providing information about their legal rights and processes. They may also

empower them to manage their health and wellbeing by maintaining procedural due process. Thirdly, lawyers may actively support clinical goals by promoting clients' concerns and needs to treatment teams, and facilitating a dialogue between parties involved in compulsory treatment, before and during legal processes. This interaction may improve the quality of treatment and health care that clients receive.

3.2.3 Theme 3: Challenges and dilemmas.

Theme 3 discusses the literature highlighting the challenges and dilemmas lawyers may experience representing clients in the mental health law context. These include difficulties determining the best way to advocate for their clients, a phenomenon described in the first theme, and other practical challenges to performing this role. This theme is divided into four subthemes, which are: i) preparation and instructions, ii) medical dominance, iii) prevailing sanist attitudes within the mental health system, and iv) training for the mental health lawyer's role.

3.2.3.1 Preparation and instructions.

Several sources show that inadequate preparation time for hearings hampers lawyers' ability to obtain adequate instructions from clients, which is necessary for effective legal advocacy. Some researchers contend that low preparation time restricts lawyers' ability to communicate with their clients (Du Fresne, 2003). It adversely affects lawyers' advocacy potential, including collecting evidence and witnesses in support of clients' instructions, seeking alternatives to involuntary commitment and providing legal advice (Carney, 2012; Perlin & Weinstein, 2016). In articles by Beaupert (2009) and Carney, Beaupert, et al. (2008), some lawyers and consumers revealed that lawyers often met with clients on the day before or on the day of hearings. The lawyers stated that this was insufficient time to research clients' cases, relay their concerns, understand medical and legal situations and determine best advocacy approaches to "counterbalance" the hospital's evidence (Beaupert, 2009, p 96). In addition, lawyers described that low preparation time negatively impacted rapport, which is important for ensuring that lawyers worked "not so much in place of the client, but alongside them" (Carney, Beaupert, et al., 2008, p. 15).

Two studies capturing patients' perspectives suggest that low preparation time by lawyers may decrease patients' satisfaction with advocacy and representation of their cases. Dolan et al. (1999) found that some patients were not fully happy (n = 12; 17%) and some patients were discontent (n = 13; 19%) with their lawyers in MHRT hearings. Among patients who were

dissatisfied, some wished their lawyer had spent more time with them to explain their case (n = 30; 43%). Similarly, Ng et al. (2016) found that one New Zealand forensic patient was dissatisfied with how little time the lawyer had spent with him or her discussing his or her case.

Related to lawyers' preparation for hearings, two studies found that lawyers did not develop strong legal arguments to support clients' cases, therefore decreasing their ability to ensure accuracy and fairness. In Thom et al.'s (2015) study, a legal tribunal member stated that lawyers sometimes inadequately prepare for hearings. The tribunal members revealed that although lawyers present clients' views and challenge evidence, they do not present adequate written submissions and legal arguments in support of clients' cases. Dolan et al. (1999) also found that some patients (n = 9; 13%) were dissatisfied with their lawyers' line of arguments.

Three studies, however, indicate that more preparation time may not necessarily strengthen lawyers' ability to obtain adequate instruction or provide stronger evidence, due to the severity of their clients' illnesses. In Carney and Tait's (2011) article, lawyers explained that they find it difficult to develop lines of arguments when clients' instructions are unrealistic; for example, one client claimed to be the Virgin Mary. Similar findings are visible in research conducted by Carney, Beaupert, et al. (2008) and Beaupert (2009). Some of the lawyers who participated in their studies explained that sometimes psychotic and delusional consumers are so unwell that they are unable to adequately instruct their lawyers (Carney, Beaupert, et al., 2008). Furthermore, in both studies, the lawyers revealed that preparation time was not needed because clients' instructions often changed before hearings and they were unwell to the point that they were unlikely to be released from compulsory treatment.

3.2.3.2 Medical dominance.

Numerous sources identified that medical information influenced lawyers' advocacy decisions, often resulting in them opting to act in clients' best interests rather than on their instructions. Four sources illustrate that lawyers' knowledge of the severity of illness and risk of danger may encourage them to support hospitalisation. According to Du Fresne (2003), and Perlin and Lynch (2016), some lawyers provide weaker advocacy if they believe that their clients would benefit from hospitalisation. Two studies support these claims. In Carney and Tait's (2011) study lawyers explained feeling uncertain about the credibility of clients' instructions due to the symptoms of their mental illness. Therefore, during review proceedings they "made explicit" clients' instructions, for example saying that "my client has asked me to say..." (p. 146), to separate personal views, about what is in clients' interests, from the instructions they

have received. Similarly, Luchins, Cooper, Hanrahan, and Heyrman's (2006) study found that lawyers were more likely to recommend hospitalisation if they perceived clients to be responsible for the occurrence of mental illness or danger. Eighty-nine lawyers were surveyed in Illinois, United States to examine lawyers' attitudes about patients' responsibility for mental illness and its influence on involuntary commitment choices. Lawyers rated the appropriateness of involuntary commitment after referring to different client situations in three vignettes. Judgment scales were: "1 = no role in judgment and 7 = significant role in judgment" (p. 496). Findings revealed that lawyers' views that clients were "responsible for the onset and recurrence of mental illness" (p. 497) significantly increased support for hospitalisation "Pearson's r 0.31, p .05; r 0.41, p .01 for onset and recurrence attributions, respectively" (p. 495). Additionally, lawyers' beliefs about their client's risk of causing harm significantly increased choices to support hospitalisation (mean score = 5.7; SD = 1.4).

Some of the literature reviewed suggests that lawyers may depend on psychiatrists and medical evidence to inform their understanding about clients' capacity and the believability of their instructions. In Carney, Beaupert, et al.'s (2008) study, lawyers doubted the credibility of their clients' instructions, their understanding of their mental condition or their ability to make appropriate decisions for personal treatment and care. Some researchers postulate that lawyers may believe that they have limited medical expertise to assess clients' capacity (Perlin & Lynch, 2016; Winick, 1999). Morris (2009) explains that lawyers' lack of confidence about this issue may be due to the belief that psychiatrists are better trained to assess capacity.

Some sources suggest that like tribunal members, lawyers may also rely on psychiatrists to supply evidence that is relevant to tribunal decision-making about patients' discharge, which limits their ability to advocate for their clients. This evidence includes the legal criteria for compulsion and the extra-legal and non-medical factor of *insight*. A study on the functioning of England and Wales' MHRT by Perkins (2003) found that tribunal members tended to define mental disorder criteria, for patient discharge from compulsory treatment, using psychiatric diagnostic labels or the mental disorder categories, as defined by the United Kingdom Mental Health Act. The study evaluated the content of planned MHRT reforms through non-participant observations of 61 tribunal processes and in-depth interviews with tribunal members ($n = 24$), in England and Wales. Analysis of the interviews and observations revealed that the terms *nature* and *degree* of the United Kingdom Mental Health Act's mental disorder criteria were usually accepted as medical concepts and aligned with psychiatric opinion (pp. 228-229). Nature was interpreted with reference to the medical evidence about the patient, including

diagnosis, history of illness and prognosis, while psychiatric opinion generally informed tribunal members' interpretation of degree.

Similarly, other sources claim that insight is often inconsistently interpreted and medicalised by tribunal panels, internationally (Diesfeld, 2003) and in New Zealand (Diesfeld, 2013). Both sources suggest that inconsistency and medicalisation poses challenges for lawyers to maintain due process and argue for its existence or non-existence. While the meaning of insight is contested, it is usually defined as patients' agreement with psychiatrists' diagnosis including their awareness of their mental condition and its implications on their behaviour, compliance with treatment and patients' understanding of their need for treatment (Diesfeld, 2003). Diesfeld and Sjöström's (2007) study investigated the influence of insight in decisions made by the MHRB in Victoria, Australia, through analysis of 25 cases. They suggest that it was difficult for lawyers to challenge insight because it is accepted as a psychiatric concept of which they have limited knowledge.

Several studies suggest that lawyers may experience difficulties cross-examining medical evidence because it is favoured over non-medical evidence in tribunal decision-making. One of the aims of a Northern Ireland study, conducted by Campbell (2008), on legal advocacy in the mental health law context was to obtain solicitors' experiences and perceptions of practising in MHRTs. Various methodologies were adopted including surveys with 30 solicitors who had engaged in tribunal work. The solicitors described experiencing difficulties cross-examining medical evidence because the medical tribunal member had disproportionate influence in the proceedings. Similarly, in Carney, Beaupert, et al.'s (2008) study, lawyers described being unable to challenge medical evidence because it weighed disproportionately in tribunal decision-making compared to the evidence presented by social workers, patients or nurses. Carney and Beaupert (2008) postulate that to lower medical dominance in tribunal decision-making and improve the quality of legal representation, it is important that "genuinely interdisciplinary multi-member MHTs" (p. 19) strive to balance and meet clients' legal, medical and social (participation and fairness) needs.

Medical dominance in tribunal processes not only decreases lawyers' ability to advocate for clients but also adversely affects patients' satisfaction with the legal processes and their lawyers. Ng et al. (2016) found that several patients were dissatisfied with their lawyer because they did not challenge the doctor about the accuracy of the evidence supporting involuntary commitment. Likewise, in Dolan et al.'s (1999) study, more than half the patients (n = 37;

53%) did not identify legal representatives as having significant influence on tribunal proceedings and outcomes, compared to the RMO's (medical practitioner) opinion.

Several articles and studies, however, maintain that the dominance of medical evidence may be used advantageously by lawyers to promote clients' therapeutic goals. Carney's (2012) article about the role of MHTs in "advancing goals such as fairness, legality of detention and access to treatment" (p. 1) draws from data reflecting clients' and stakeholders' concerns about participation and engagement in review processes. He argues that lawyers could change "styles or rituals of communication" (p. 27) by encouraging collaboration and dialogue between health professionals, tribunal members and patients. Carney posits that conversation is better than mechanical questioning of adversarial processes. Beaupert (2009) and Carney (2011) contend that in truth-seeking lawyers can facilitate clients' participation in the decisions made about their treatment and care. These sources suggest that the patient's participation can increase the accuracy of decision-making and their perception of how fair the decision-making was, therefore supporting their long-term wellbeing. However, in an article by Carney (2012) that draws from a wider study on MHTs, lawyers stated that they were unable to effectuate material changes to clients' social and treatment grievances due to the limited powers of MHTs to address extra-legal issues (Beaupert, 2007).

3.2.3.3 Prevailing sanist attitudes within the mental health system.

Several legal commentaries claim that prevailing discriminatory attitudes towards mentally unwell persons may deter lawyers from zealously advocating for clients and acting in their best health interests. Perlin and Weinstein (2016) and Perlin and Lynch (2016) outline four concepts: sanism, pretextuality, ordinary common sense and heuristics, that can contribute to inaccurate, unfair and anti-therapeutic advocacy and, therefore, judicial decision-making. Sanism is an unconscious bias among professionals involving untrue assumptions about mentally unwell persons. This includes that they are lazy, irresponsible and culpable for their illness. Pretextuality is decision-making based on sanist assumptions, including ad-hoc or predetermined, inadequate evidence; selective-reading of evidence; and inaccurate application of the laws based on these assumptions. Ordinary common sense is the disparity between perceptions and reality; this means that decisions are made based on what mental illness is perceived to be by decision-makers rather than the facts of the case at hand. Finally, heuristics thinking involves simplification of a complex decision-making process. Decisions are based on prior decision-making or theory rather than the information of the case which does not confirm these theories. Academics posit that such views among professionals inadequately

protect patients' rights, compromise on accuracy of court decision-making, are perceived as unfair by patients and are anti-therapeutic to them.

There is also some evidence that lawyers may be disinclined to vigorously advocate for clients due to concerns about spoiling their own reputation among judges and psychiatrists or belittling the knowledge and training of psychiatrists (Perlin, 1992; Perlin & Lynch, 2016). According to Perlin and Lynch, lawyers may feel "foolish" and "awkward" (p. 306) representing clients' instructions that are extraordinary to the courts, because judges would assume that the arguments derive from them. However, two studies indicate that other professionals' attitudes may not affect lawyers' views or choice of advocacy in legal processes. Luchins et al. (2006) found that mental health professionals' and judges' views of patients' needs for involuntary hospitalisation did not strongly influence lawyers' judgments or advocacy choices. Similarly, in Carney, Beaupert, et al.'s (2008) article, lawyers stated that they adjust advocacy techniques, for example, questioning psychiatrists sensitively so as not to offend them.

3.2.3.4 Training for the mental health lawyer's role.

Little is known about the impact of training on legal representation in the mental health law context. Existing evidence shows inconclusive findings about the impact of training on the strength and rigour of legal advocacy. Two sources, for example, identify training in numerous areas as important to improve the quality of legal representation in this context. Rogers (1994) contends that training about mental illness categories, medications, doses, side-effects and the impact of mental illness on behaviour would equip lawyers to cross-examine psychiatrists' diagnoses and treatment plans. In Campbell's (2008) study, solicitors had a shallow understanding of mental health law and described having received limited ongoing training for their role. Campbell suggests that limited knowledge and training have ramifications for weaker advocacy.

Several sources maintain that mental health training is not enough, but that attitudinal and sensitivity training is also important to increase lawyers' provision of vigorous advocacy in this context (Perlin, 1992; Perlin & Lynch, 2016; Perlin & Weinstein, 2016; Poythress 1979). Poythress (1979) found that mental health training did not increase lawyers' cross-examination of psychiatrists. The study assessed whether training about psychiatric-illness categories increased lawyers' cross-examination in involuntary commitment hearings. It used three participant groups, consisting of trained, untrained, or contaminated (aware of research but not trained) lawyers in Austin, Texas, United States. The behaviour of all three groups was coded

and statistically analysed. The trained group underwent training in cross-examination techniques, mental illness categories and predicting dangerous behaviour. The findings revealed that training did not have a significant effect on lawyers' cross-examination of medical evidence in the courtroom and was ineffective without attitudinal training. Perlin and Lynch (2016), Perlin and Weinstein (2016), and Perlin (1992) argue that attitudinal training is vital to combat the biases and prejudices, described in the last section, that permeate the mental disability system. They also emphasise that training about the cultural, political and social circumstances of mentally unwell persons would change lawyers' attitudes, enabling them to see biases in their views and in the practices in the mental health law system.

In summary, Theme 3 highlighted the challenges and dilemmas lawyers may experience performing the mental health lawyer's role, perpetuating the adoption of best-interest rather than adversarial approaches in the contemporary context. Several studies and commentaries show that inadequate preparation for hearings may adversely affect obtaining clients' instructions and lawyers' determinations of how to best advocate for clients. Secondly, lawyers may be reluctant to cross-examine medical evidence, or assess clients' capacity, due to the reality of their client's illness and the belief that they have limited medical experience compared to psychiatrists. Additionally, there is a culture of medical dominance in the mental health system which favours medical evidence over contesting viewpoints. Thirdly, prevailing sanist attitudes in the mental health system, and preservation of professional reputations, may lead to provisions of weaker advocacy. This has negative implications for accurate decision-making, patients' satisfaction with legal processes and promotion of clients' instructions. Finally, there is limited evidence about the impact of training on mental health lawyers in practice. Two studies illustrate that mental health lawyers are inadequately trained, while one of them highlights the limitations of psycho-legal education training in improving the quality of adversarial advocacy. The legal commentaries identify the need for educated and sensitive mental health lawyers to increase cross-examination and provisions of vigorous advocacy.

3.3 Discussion

The integrative literature review identified 50 articles, editorials, legal commentaries and qualitative, quantitative and mixed-methods studies that are relevant to legal representation in the mental health law context across various jurisdictions. Several articles and studies have been published in the last year (Ng et al., 2016; Perlin & Lynch, 2016; Perlin & Weinstein, 2016). Research on alternative forms of legal representation is also relatively new and

proliferating in recent times (Daicoff, 2006; Freckelton, 2003; King et al., 2009), evidence of growing research on legal representation in the mental health law context.

Several sources highlight that the lawyer's role in the mental health law context is to protect patients' liberty rights (due process and accuracy). They also show that mental health lawyers have the potential to achieve positive short-term and long-term health outcomes for clients and contribute to improved access to quality health care when clients are unlikely to be released. However, lawyers face numerous challenges to providing optimal legal representation. These obstructions include inadequate preparation for hearings, a reluctance to engage in the medical field, cultures of medical dominance and prevailing sanist attitudes in the mental health law system. Inadequate training in psycho-legal concepts and the attitudes that pervade the mental health system may also be a barrier to rigorous advocacy. The literature suggested that to improve the quality of legal representation, it is important that lawyers understand their role, have more time to prepare for hearings, receive adequate training about best practice, understand how to interpret legal and extra-legal criteria independent to psychiatrists and use the inquisitorial hearings advantageously. However, it is evident that lawyers may not be able to promote liberty rights when patients are unwell, lack capacity or cannot communicate with their lawyers. In such situations, lawyers may have no choice but to facilitate positive health outcomes and support their clients' therapeutic goals, to the extent that their advocacy role permits.

The literature, however, was limited in many ways. Most of these sources were written by professionals for professionals (n = 20), or were part of a wider research on MHTs (n = 13). Little research has been undertaken specifically on the role of lawyers in mental health contexts, by outsiders to the context. The empirical studies adopted a diverse range of methodologies, including quantitative and qualitative (case analysis, questionnaire, interviews obtaining patients' and tribunal members' perspectives). However, these studies were not necessarily reflective of lawyers practising in the field. Most studies did not, for instance, include the perspectives and lived experiences of lawyers regarding their role and experiences of representing clients. For example, case analysis and court observations reflect lawyers' practice and evidentiary issues they may face, but do not give them an opportunity to explain their actions or recount experiences (Diesfeld & McKenna, 2007; Thom et al., 2015). Patients' perspectives highlight dissatisfaction with legal advocacy, yet they do not outline the challenges experienced by lawyers in asserting patients' rights (Dolan et al., 1999; Ng et al., 2016). Statistical studies can show that training interventions are ineffective (Poythress, 1979),

yet they do not explain how these initiatives could be designed to meet lawyers' training needs. Only a small number of articles highlighted lawyers' perspectives on legal representation (n = 9). In most studies, the findings on the lawyer's role were a bi-product of wider studies on MHTs and provided little information from lawyers' perspectives (n = 7). Moreover, most of the evidence is from the United States and Australia, and only a small number are from New Zealand (n = 9). Within the New Zealand literature, the methodologies employed include case analyses (n = 3), legal commentary (n = 4), hearing observations, and/or interviews with non-lawyer participants (n = 2). None of the New Zealand literature reflects mental health lawyers' experiences of legal representation from their perspectives.

3.4 Summary

Overall, the literature review revealed that there was limited literature published internationally, and within New Zealand specifically, pertaining to lawyers' experiences and perspectives of representing clients in the mental health context. Further research in this area is important to practising lawyers, educationalists, legal reformists and policy makers, as argued in the previous chapters, to improve the quality of legal representation in the mental health law context and achieve accurate, fair and therapeutic outcomes for this vulnerable population. Lawyers are also the only professionals independent of the MHA 1992 who are employed specifically to represent and advocate for mental health patients in hearing and review processes. On this basis, a study was designed to investigate the following research question: What are lawyers' experiences and perspectives of representing clients under the MHA 1992? The next chapter will describe the methodology chosen to answer the research question.

CHAPTER FOUR: RESEARCH METHODOLOGY

Chapter 4 describes the study's research design. The first part of this chapter outlines the aims and objectives and the philosophical underpinnings of this exploratory, qualitative descriptive study. The second part of this chapter describes the methods: the sampling approach, the process of participant recruitment, and data collection and analysis techniques. It also discusses the measures taken to ensure the rigour of the study and the ethical issues considered in designing and executing this study.

4.1 Aims and Objectives of the Study

The overarching aim of this study was to explore and describe the experiences and perspectives of lawyers who represent clients under the MHA 1992.

The objectives of the study were to:

- i) Describe the core functions of lawyers as they prepare and advocate for mental health patients.
- ii) Explore the barriers and facilitators to providing effective legal representation to clients.
- iii) Identify the dilemmas lawyers face during preparation and advocacy stages of mental health hearing and review processes.
- iv) Understand how lawyers approach and overcome the challenges to providing effective legal representation to clients.
- v) Identify lawyers' training and support needs and recommendations to improve their practise in the mental health law context.

4.2 Research Methodology

The purpose of research is to increase knowledge about a social phenomenon within a philosophical framework. Assumptions about the meaning of knowledge and the means of acquiring it form the basis of all research (Scotland, 2012). The research framework used to guide the formation of the methodology for this study involved considering four elements: ontology, epistemology, axiology and methodology (Creswell, 2013). These elements are described below.

- Ontology questions what is reality and whether it is separate to (objective), or intertwined with, human practice (subjective).
- Epistemology questions what can be known, the legitimacy of knowledge and the relationship between the researcher and knowledge.
- Axiological assumptions acknowledge that research is value-laden. It emphasises that the researcher explicitly acknowledges personal values, assumptions and philosophical position to increase the transparency of research for readers and future researchers.
- The methodology is the overall research approach which is underpinned by ontology, epistemology, and axiology. It affects the techniques adopted for data collection and analysis.

The researcher's choice of methodology and decisions about whether to conduct qualitative or quantitative research reflects their assumptions about reality and the process of acquiring knowledge (Scotland, 2012). In this inquiry process, my ontological and epistemological assumptions contributed to the development of the research question and choice of methodology and the methods which were adopted. I outline my theoretical position in the following sections.

4.2.1 Qualitative research design.

Qualitative research was considered to be the best framework to answer the research question, "What are lawyers' experiences and perspectives of representing clients under the MHA 1992?" While it is possible to use statistical analysis to make generalisations and claims about the effectiveness of legal representation in mental health contexts (Crotty, 1989; O'Brien et al., 1995), quantitative research fails to capture the complexity of human experiences and emotions (Crowther-Dowey & Fussey, 2013). An exploration of professional perspectives and a summation of their experiences is achievable by qualitative methodology (Smythe & Giddings, 2007).

There were several reasons why qualitative research was considered as the optimal framework to answer the research question of this thesis. Firstly, researchers have described qualitative research as useful for the study of professional experiences and perspectives in health research (Neergaard, Olesen, Anderson, & Sondergaard, 2009). Researchers acknowledge that subjective knowledge resulting from qualitative research can highlight vulnerabilities in health-care systems, is critical to assessing the quality of current service provision and may be useful to shaping health-care practice and service delivery (Smythe & Giddings, 2007), which

is relevant to the participants in this study who operate within a medico-legal milieu. An understanding of individual experiences and perspectives fulfils the objectives of this study which is to gain insights into complex and specific practices of lawyers in the mental health law context, and also allow for the identification of areas of practice, policy and law in need of improvement. Therefore, qualitative research was the best approach because it provided unique insights into inconsistencies in legal practice which may aid the future development of practices and services that meet the needs of lawyers and clients and aid the protection of civil liberties.

Secondly, the study is also exploratory in nature; no other research has been conducted on lawyers in the mental health law context in New Zealand. There is evidence that a qualitative methodology is appropriate for an exploratory study because it captures and values the reality of participant experiences and viewpoints (Angen, 2000; Sandelowski, 2010). Qualitative research seeks to generate understandings about a social phenomenon by identifying and describing patterns in the data, resulting in insights that may not have been previously known (Braun & Clarke, 2006). There is much that is unknown about the lawyer's role in the mental health law context, thus qualitative research was considered an optimal approach to answer the research question.

Finally, qualitative research allows for the description of the reality of a professional's practice to be the sole focus of attention. Professional perspectives are rarely obtained and seldom contribute to shaping service administration. In New Zealand, some lawyers are dissatisfied with the lack of consultation between the Ministry of Justice and legal practitioners about legal service reformations (RadioNZ, 2016a, 2016b, 2016c). Sandelowski (2000) explains that a frequently adopted qualitative research approach, aiming to preserve participant testimonies and bring to the forefront their knowledge about a social context, is qualitative descriptive research. Therefore, this research uses qualitative descriptive research to provide a "comprehensive" account of individual stories and the meaning they bring to it (p. 334).

4.2.2 Qualitative descriptive research.

In this study, qualitative descriptive research was used to explore and describe lawyers' experiences and perspectives of representing clients under the MHA 1992. Qualitative descriptive research aims to uncover the "who, what and where of their experiences" (Sandelowski, 2000, p. 338). This framework enabled an exploration of professional perspectives and summation of their experiences. It also generated comprehensive knowledge

about legal representation in the New Zealand mental health law context and provided novel insights into aspects of the lawyer's role as experienced and described by them.

Qualitative descriptive research is becoming a popular approach to understanding and assessing the quality of health service provision (Neergaard et al., 2009; Sandelowski, 2000; 2010). It aims to enhance understanding of a social issue, specify variables, compare the chosen social phenomenon across contexts and validate and revise theory (Braun & Clarke, 2013; Creswell, 2013; Guba & Lincoln, 1994). A study's findings may differ to current knowledge about a social context and will, therefore, add to this knowledge about the social phenomenon. One of the aims of this study was to see whether New Zealand lawyers' experiences and perspective are similar to or deviate from existing knowledge about effective legal representation in the mental health law context.

The philosophical underpinning of this qualitative descriptive research is post-positivism. Post-positivism is a worldview which has critical-realist ontological assumptions and encompasses both realist and relativist viewpoints (Braun & Clarke, 2013). Post-positivism assumes that there is an objective reality; however, it is only partially accessible from individual perspectives and experiences (Angen, 2000; Creswell, 2013). A constructivist perspective of knowledge is assumed, meaning that there are multiple realities and an individual's cultural, historical and social backgrounds influence the meanings they ascribe to a situation (Guba & Lincoln, 1994). The researcher can come close to discerning an objective reality by highlighting commonalities among multiple subjective realities (Crowther-Dowey & Fussey, 2013). Western law has positivist underpinnings, meaning that it is assumed to be rational and true (Brookbanks, 2005a). Based on this worldview, legal criteria, legal guidelines and legal rules would influence and guide lawyers' professional practice. However, lawyers' perceptions about their role and the practices that work well, and those that should be improved, would differ depending on their experiences and legal specialisations. It is important to understand their views on useful practices to revise current understanding of best-practice legal representation. This study aimed, therefore, to provide in-depth descriptions of lawyers' individual experiences and perspectives of their role and highlight the commonalities and differences among them.

The axiological assumption of post-positivist research is that it is value-laden and meaning is created by the researcher and participant (Creswell, 2013). It is important that the researcher understands their own assumptions and interests and how these affect the knowledge-acquiring process. My positionality in relation to effective legal representation in the mental health law

context has been impacted by previous interests and readings of international law, New Zealand mental health legislation and academic literature (see Chapters 2 and 3). As an immigrant, I am passionate about whether minority and vulnerable groups' human rights are upheld in practice. My past work experiences have also shaped my human rights interests and perspectives on rights-protection issues. For example, I interned at the United Nations where I designed small projects that aimed to promote human rights law principles and worked at a homeless shelter with people suffering from mental health issues. My knowledge about human rights issues also grew from a summer research studentship at the University of Auckland and a research internship at The Hallmark Disability Research Initiative at the University of Melbourne, both of which involved exploring the impact of the United Nations Convention on the Rights of Persons with Disabilities in practice. These experiences have contributed to my concerns about human rights violations of mentally disabled persons, such as the rising rates of CompTOs and that patients' rights and needs are not met. All of these previous experiences influenced my decision to better understand how lawyers in the mental health law context attempt to meet international disability law standards. My previously acquired knowledge also influenced the questions I asked of lawyers. The interview topics (see Section 4.3.4) were predetermined, based on findings in the academic literature and human rights law principles, while participants were free to discuss experiences and views which deviated from prescribed questions.

Qualitative descriptive methodology was the optimal choice because it brings to the forefront participants' views on the research topic rather than the researcher's areas of interest (Sandelowski, 2010). Neergaard et al. (2009) argue that qualitative descriptive research is a pragmatic approach to gaining insights into issues in health-care systems, professional needs and ways to achieve quality service delivery. Qualitative descriptive research provides straightforward descriptions of an event from individual knowledge and perceptions, aiming to describe rather than explain a social phenomenon (Sandelowski, 2000). The goal is to provide a "comprehensive summary of events in the everyday terms of those events" (p. 334). Sandelowski (2000) recommends that the researcher should stay close to the surface of data and not deviate substantially from participants' description of events and the meanings they attribute to them. In this study, it was important that the meaning lawyers ascribed to legal representation were not altered or "re-presented" (p. 338) as straight descriptions were thought to be more useful to the audience of lawyers, practitioners, planners, policy makers and

educationalists in mental health law, and may help shape policy and improve practice to enhance the quality of legal representation and its impact on patients.

A qualitative descriptive study design is suitable when the researcher carries out the research independently and resources, research and time are limited (Neergaard et al., 2009). I conducted the research alone within the limited timeframe of a master's-level thesis. Therefore, a qualitative descriptive design was the appropriate method choice. My research supervisors guided me and critiqued and reviewed the research process throughout the study.

4.2.3 Limitations of qualitative descriptive research.

Qualitative research is not without limitations. According to Neergaard et al. (2009), a criticism of qualitative descriptive research is its limited generalisability. Additionally, it is relative to the particular social context that is studied. Despite qualitative research findings being contingent on the social context being studied, the value of findings that provide a rich understanding of the phenomenon is not diminished. Although the study findings increased knowledge about Auckland and Waikato lawyers' experience and perspectives of their role in the mental health context, they are unique to the study sample and are not reflective of all New Zealand or international lawyers' views on their practice. The discussion chapter (Chapter 7) acknowledges the study's limitation.

Neergaard et al. (2009) and Sandelowski (2000) highlight that although there is low-inference interpretation in qualitative descriptive research, it is questionable whether straight descriptions are value free. The "perceptions, inclinations, sensitivities and sensibilities" of the researcher may influence the analysis process and their choice of excerpts to support findings (Neergaard et al., 2009, p. 4). The researchers recommend that a rigorous method of data analysis is adopted and detailed to increase the trustworthiness of research (see Section 4.4 Rigour, below).

4.3 Research Methods

This section describes the methods for data collection and analysis. Additionally, it outlines the study sample, recruitment procedures and ethical considerations. Furthermore, it highlights the measures taken to ensure rigour in this research. Throughout this section, I have attempted to be transparent about my values and assumptions while collecting and analysing data and the impact of these values and assumptions on any decisions made during the research process. Creswell (2013) describes researchers who are critical of the data collection methods and tools

as exemplifying functional reflexivity. He further recommends that researchers are mindful of the factors affecting data collection and analysis, throughout the research process, to strengthen the research process.

4.3.1 Study sample.

Potential participants were identified using purposeful sampling. Purposeful sampling is a common method of recruitment in qualitative descriptive research (Neergaard et al., 2009). It involves the researcher intentionally selecting participants who can provide in-depth and high-quality data for the study (Suen, Huang, & Lee, 2014). Participants were approached from a sample of Auckland and Waikato mental health lawyers who are on the legal aid Mental Health Roster (approx. $n = 45$). The study sample included lawyers who provide legal representation to clients in one or more of the following mental health hearing and review processes: The section 16 review, the section 18 review and/ or the defended CompTO hearings and MHRT hearings (explained in Chapter 2).

Eleven lawyers partook in individual face-to-face semi-structured interviews. Researchers agree that a study's sample size is relative to the social context being investigated (Braun & Clarke, 2006). Numerous factors, including the study population size, the purpose of the inquiry, study design and time-availability, influence the researcher's sample size choices (Braun & Clarke, 2013). The sample size ($n = 11$) was sufficient given the population size of mental health lawyers in Auckland and Waikato ($n = 45$), the aims of qualitative descriptive research design, and the time constraints of a one-year master's-level thesis study. Eleven interviews were sufficient, also, because of data saturation. Fusch and Ness (2015) explain that "data saturation" refers to the process whereby the researchers become aware that enough information and data have been obtained to replicate the study and adequately answer the research question. This means that no new information is being acquired and data cannot be coded further. Fusch and Ness argue that smaller studies reach data saturation faster than larger studies. I realised that 11 interviews were enough to answer the research question adequately because I obtained rich and novel information from practitioners with specialised knowledge on the research topic, which is an under-researched field. Additionally, the information obtained from the semi-structured interviews and coding patterns became repetitive towards the end of the last few interviews. For example, as I analysed interview 11, I noticed no new themes.

This study is similar in size and design to other qualitative descriptive studies. A study by Kayes, McPherson, Taylor, Schlüter, and Kolt (2010), for example, researched the facilitators and barriers to engaging in physical activity among people diagnosed with multiple sclerosis. The study sample was 10 participants; the methodology was qualitative descriptive research, and semi-structured interviews were the method of data collection. Given the similarities in research question and study design of the research by Kayes et al., and the objectives of my study, a minimum of 10 participants was considered an appropriate sample size. As an individual researcher working within a restricted time frame, the sample was a practical size to provide the depth and quantity of data necessary to meet the study's objectives.

Inclusion criteria included male and female lawyers who represent clients in hearing and review processes under the MHA 1992. I recruited lawyers from the Auckland and Waikato regions due to close geographical proximity to my residential location of Auckland. Given the small number of mental health lawyers who represent patients under the Act, I included all lawyers on the legal aid funded Mental Health Roster. I also included lawyers who had limited mental health law experience, on to the presumption that they would provide unique insights. This addition resulted in the recruitment of mental health lawyers with varying degrees of experience, thus increasing the sample's representation of the population of lawyers who practise under this legislation. Lawyers with different legal backgrounds and specialties such as family, criminal, commercial and immigration law were also included for their ability to provide diverse insights and broaden the study sample.

Exclusion criteria included mental health lawyers from parts of New Zealand other than Auckland and Waikato, due to geographic distance from the researcher. Additionally, lawyers who had only represented clients with mental health issues in areas other than mental health law were excluded due to lack to relevance to the research question. Lawyers who had only represented mental health patients in hearings other than mental health hearings and review processes, such as criminal or family proceedings, were not interviewed for the same reason.

4.3.2 Recruitment process.

Lawyers were invited to participate in this research directly and indirectly. I contacted potential participants via email and if they were interested in this research they responded. Lawyers' email addresses were available on the ADLS website. I followed-up with an email or phone call to book an interview at a time and place of their convenience. The email consisted of an invitation, a participant information sheet (PIS) and consent form (CF; Appendices G and H).

The PIS and CF outlined the aims of the study and requirements for participation. I also recruited potential participants with the assistance of the ADLS; they provided potential participants with the same information. Lawyers were invited to contact me or my supervisors by email to inquire about the study. I describe the different processes of recruitment in Auckland and Waikato regions, below.

4.3.2.1 Recruitment in Auckland.

I contacted the Committee to assist with recruitment by emailing potential participants. The Committee is responsible for the administration of the Auckland-wide Mental Health Roster which ensures that all patients subject to the MHA 1992 have access to legal advice. In Auckland, there are two rosters: one in Auckland City and the other in South Auckland. Both rosters consist of lawyers who represent clients in mental health hearing and review processes (ADLS, 2010). The Committee emailed potential participants (n = approx. 40) in the Auckland region with information about the study and an invitation to participate. This process was not effective and I was only able to recruit two lawyers. One month later I directly invited Auckland mental health lawyers to participate in this study. A much more successful outcome resulted, with seven lawyers indicating an interest in participating. One lawyer withdrew from the study. Altogether, I interviewed eight Auckland mental health lawyers.

4.3.2.2 Recruitment in Waikato.

I recruited Waikato lawyers with the help of a local district inspector (DI) or lawyer appointed by the Ministry of Health. The DI allocates patients facing formal legal proceedings to mental health lawyers. Again, the DI emailed participants with a PIS and CF and an invitation to participate in the study. In Waikato, indirect contact was more effective than in Auckland. Out of five lawyers, four indicated an interest in participating in this study. I successfully followed-up and interviewed three of them.

4.3.2.3 Challenges recruiting participants.

There were challenges to meeting the target sample size. Initially, there were few responses from Auckland and Waikato lawyers. This may be because the lawyers were busy and unavailable to be scheduled for an interview. Reluctance to participate may also have been due to the complex and sensitive nature of legal representation under the MHA 1992. Some lawyers had recently begun practising in mental health law and stated that they had limited mental health experience and were unable to answer the interview questions. Lawyers who participated highlighted their concern for confidentiality. Despite challenges to recruitment,

overall, purposive sampling enabled recruitment of participants who could provide rich data and a good representative sample of the potential pool. I was also able to answer the research questions comfortably.

Table 3, below, provides a numerical description of the study sample’s characteristics, including number of participants, gender, age range, range of years they have worked in law, and years worked in mental health law and in fields other than mental health law, proportion of work they commit to under the MHA 1992 and representation of ethnicities. The sample was an adequate representation of the pool of mental health lawyers in Auckland (approx: 20%) and a good representation of Waikato mental health lawyers (approx: 60%). I recruited more male than female participants. Additionally, most participants were New Zealand European or Pākehā.

Table 3

Description of Participants

Characteristics	N
Participants	11
Male	8
Female	3
Age range	45-80
Experience as a lawyer (range)	12 – 56
Experience in mental health law (range)	>1 – 26
Proportion of work in mental health law	5% - 50%
Ethnicity (list)	Māori (n = 1) and New Zealand European/ Pākehā (n = 10)

4.3.3 Semi-structured interviews.

The chosen data collection method was individual face-to-face semi-structured interviews. All the interviews were audio-recorded and I transcribed them verbatim with the participants’ consent.

Semi-structured interviews enable the researcher to determine the topics discussed while giving participants the freedom to talk freely about diverse and unique experiences (Crowther-Dowey & Fussey, 2013). In an under-researched area, it is important that participants can direct the

conversation and discuss experiences and issues of relevance to them. However, I also wanted to ensure I covered all relevant topics. These topics were predetermined based on theories in the literature about the lawyer's role in the mental health law context (outlined in Chapter 3).

Semi-structured interviews are particularly useful to highlight similarities and differences between participants about a social context or issue. Reiner (1991) undertook semi-structured interviews with criminal justice professionals and obtained unique accounts of professionals' views and the "variations" which exist among them" (p. 51). This study also aimed to identify variations in lawyers' perspectives on their role and the representation they provide. Open-ended questions captured a range of different ideas which would not have been possible in a structured interview.

4.3.4 The interview schedule.

The interview schedule consisted of six topics and 16 questions about legal representation (Appendix I). Prompting questions were noted down under overarching questions to encourage participants to elaborate on a topic if they revealed limited information. The interview schedule topics were: i) preparation for the hearing, ii) communication with clients, iii) effective/optimum representation in hearings, iv) advocacy in the hearings, and v) recommendations for legislative and procedural reform.

Crowther-Dowey and Fussey (2013) recommend that interview questions are open-ended and broad to prevent participants' answers being influenced by the interviewer's perspective on the research topic and points worth discussing. Two examples of open-ended questions used were, "What challenges do you experience communicating with patients?" and "How do you prepare for the [hearing]?" Broad questions enabled participants to reflect on their experiences and highlight personal views without being directed to answer the question by the researcher. Prompts such as "funding" or "time constraints" were only used if participants found it difficult to answer questions.

The wording of interview questions was revised slightly after the initial interview to accommodate the reality of the participants' experiences. After the first interview, for example, I modified a question regarding access to patients. New Zealand grey literature indicates that lawyers access patients via a roster system. Initially, I worded the question as, "How does the roster system work for lawyers?" The question assumed that a roster system was in place and worked well in practice. I observed that the first participant found it difficult to answer the

question and felt that perhaps it was leading and not applicable to their practice. Therefore, I modified it to read, "How do you come into contact with patients?" The revised question allowed participants to describe, in future interviews, the process of lawyers' access to clients. This also resulted in a slightly broader range of answers than the initial question.

4.3.5 Preparation for the interview.

Before the interview process, I conducted a pilot interview with an experienced qualitative researcher at the University of Auckland's Faculty of Medical and Health Sciences. Interview techniques such as maintaining eye contact, reiterating statements and asking for clarification were discussed and practised. After the initial interview, my supervisors read through the interview transcript and provided advice on using prompts and structuring the interview efficiently to collect information on all topics. As the interviews progressed, I frequently debriefed and discussed challenges that arose, during the data collection process, with my supervisors. They consistently provided advice and enabled me to improve my interviewing style to obtain rich data.

4.3.6 The interview setting.

I conducted eight interviews in Auckland, and three interviews in Hamilton. I conducted two interviews at the lawyers' residences, one interview at the Auckland District Court, one interview at the Waikato Hospital's acute mental health unit, one at the University of Auckland's School of Medical and Health Sciences, and six interviews at lawyers' workplaces. The length of the interview depended on the work schedule of the interviewee and how much time they were willing to volunteer. The shortest interview was 47 minutes and 54 seconds, and the longest interview was 2 hours and 4 minutes. The approximate average time of the interviews was 1 hour and 20 minutes.

4.3.7 The interview process.

Creswell (2013) highlights the need for shared and built trust between researcher and participant to enhance openness and disclosure of information. I built rapport and trust in several ways over the interview process. I allowed lawyers to choose interview locations so that they felt comfortable during the process. Before the interview, I reminded participants that the purpose of the study was to understand their perspectives and experiences of legal representation and areas for improvement of practice. I also provided a short demographic form that lawyers could complete in their own time, rather than at the beginning and end of the

interview. At the start of the interview, I asked participants about their legal background and motives for involvement in mental health law before asking challenging and controversial questions about legal representation. Talking about their personal motives appeared to encourage lawyers to answer questions openly. All lawyers consented to the recording of the interviews. The ability to record the interviews was especially helpful because I was able to engage with the interviewee and probe them further without having to take notes during the interview.

4.3.8 Data analysis.

Braun and Clarke's (2006) thematic analysis was the chosen method of data analysis. Thematic analysis is used to identify, analyse and summarise themes within the data in relation to the research question (Braun & Clarke, 2006; Smith & Firth, 2011). I chose this method of analysis because it aligned with the aims and method of the qualitative descriptive research design. It enabled me to conduct semantic analysis, meaning that codes and themes were based on patterns found in the surface meaning of the data and did "not look beyond what the participant says" (Braun & Clarke, 2006, p. 84). Thematic analysis was appropriate for this post-positivist study due to its suitability for studies assuming both realist and constructionist viewpoints.

The process of thematic development is not passive; themes do not emerge from the data, rather the researcher actively seeks them (Braun & Clarke, 2006). This section, therefore, describes the data analysis process I conducted, in detail. This process included a 6-phase approach as described by Braun and Clarke.

4.3.8.1 Familiarising yourself with the data.

Phase 1 of thematic analysis was data transcription, reading and re-reading transcripts and making notes of salient information in the data set. Braun and Clarke (2006) emphasise that this an important step to engaging with the data and understanding the true essence of interviewees' perspectives. I transcribed all 11 digital recordings of the interviews verbatim; although it was time-consuming, it facilitated close reading, engagement and interpretation of the data from the beginning of the data collection process. The recordings were re-listened to at least once and compared to the transcripts, to ensure textual data accurately reflected lawyers' statements. Each transcript was read thoroughly at least two times. I noted down information which stood out to me as significant from lawyers' perspectives, and made notes on data patterns and potential codes. I categorised commonalities in lawyers' perspectives from the beginning of the data analysis process.

4.3.8.2 Generating initial codes.

Phase 2 of data analysis was generating codes. My supervisors and I coded several pages of one transcript and then shared codes to ensure consistency and increase inter-rater reliability (Pope, Ziebland, & Mays, 2000). I discussed the differences and commonalities between codes with my supervisors, and they provided me with useful tips on naming codes to capture lawyers' perspectives more broadly.

The interview transcripts were coded systematically to highlight all important points in the data set. I applied codes to short segments of the data, approximately one to two sentences long, giving each segment equal attention (Braun & Clarke, 2006). Codes did not summarise sentences, rather they described the meaning of data, therefore enabling me to organise them into meaningful categories. At this stage, I coded for all possible patterns in the data, including those that deviated from a majority of the codes. This inclusive approach ensured that information about a pattern was accurately described during the report-writing stage. I placed uncommon codes under a section labelled "lawyers' individual experiences" to highlight that each code reflected one professional's experience. I was then able to separate codes that did not fit primary themes and determine later whether they were not applicable to this research. I coded three transcripts completely; then I made a list of all codes. Altogether, I developed 69 codes. These codes were used to code data segments in the remaining eight transcripts. Sometimes, I deviated from the prescribed framework of the set list of codes if lawyers' comments did not fit into the framework, thereby enabling me to capture unconventionalities in the dataset.

4.3.8.3 Searching for themes.

The third phase of thematic analysis was searching for themes and grouping codes into themes. This involved me developing a chart and several mind maps to make sense of the data and identify trends across the dataset. I colour-coded similar information. Similar codes were then grouped together and placed in a thematic map. I then re-read data extracts to understand the meaning of similar codes to aid the development of an initial theme name that best described the pattern in the data. If codes occurred at least once across all transcripts they were placed under themes to represent commonalities among lawyers' perspectives. I copy-pasted interesting excerpts under codes and initial themes and stored them in a Word document for later stages of data analysis. I developed six initial themes. I noticed that codes across initial themes overlapped and that thematic development required more work.

4.3.8.4 Reviewing, defining and naming themes.

I undertook Phases 4 (reviewing) and 5 (defining and naming) simultaneously. I checked that codes fitted well under the themes and reviewed theme names and descriptions to ensure they reflected meaning in the data. Firstly, excerpts from the interview transcripts were examined and checked for their congruency with the themes, and compared to the dataset. Pope et al. (2000) describe this process as "constant comparison" (p. 114). They indicate that checking each item under an initial theme in comparison with the rest of the data set is an important part of "establishing analytical categories" (p. 114). Therefore, I prevented a reductionist analysis approach and captured and reflected the code's context in the description of the theme. I reviewed the five initial themes, renamed them and added additional themes to prevent overlap, to increase clarity and capture the complexity of the lawyers' perspectives. I eventually derived five main themes and multiple subthemes that are presented in Chapters 5 and 6.

4.4 Rigour

As already discussed, there is worth in researchers understanding the assumptions and values they bring to the research process (Creswell, 2013). Qualitative researchers should explicitly discuss the factors which influence data collection and interpretation, to ensure the analysis accurately reflects the meaning participants attribute to the social context (Braun & Clarke, 2006; Grant & Giddings, 2002).

Lincoln and Guba (1985) outline five criteria for judging the trustworthiness of qualitative research and establishing rigour: credibility, transferability, dependability, confirmability and reflexivity. They argue that addressing these criteria can enhance a study's credibility. Throughout the research process, I took measures to increase the rigour of the study which I outline under each of Lincoln and Guba's five criteria, described below.

4.4.1 Credibility.

Credibility shows the validity of a study; it is, therefore, the primary goal of qualitative research. A study's credibility is established when the researcher can demonstrate that they have correctly explained the phenomenon being examined. Rigorous methods, for example peer debriefing and checking that interpretations match raw data, heighten a study's credibility and ensure the truthfulness of findings from the perspectives of the research participants. I have outlined debriefing with my supervisors regarding designing the interview schedule, and data coding and "constant comparison," in the section above. Additionally, my supervisors "peer

reviewed” thesis chapters and critiqued them for improvement, thereby enabling work to meet academic standards.

4.4.2 Transferability.

Transferability is the potential of the research findings to be translated to other social contexts. Some findings, and the recommendations that result from qualitative research, may be transferable despite their subjective nature. To heighten transferability, the researcher must describe the research in detail to enable interested researchers to determine whether findings are transferable to different contexts. Moreover, readers make judgments about the trustworthiness of findings. In this chapter, I have outlined the target population and purposeful sampling techniques. This information will enable readers to evaluate the transferability of the findings.

4.4.3 Dependability.

Dependability is the reliability of the study’s findings and the replicability of the study overall. Commonly, qualitative research is seen through a constructivist perspective meaning that knowledge is socially constructed and there are multiple subjective realities (Crotty, 1989). Given that reality differs depending on the background of research participants, it is unlikely that replicated qualitative studies will produce similar findings. Therefore, it is important that the researcher reports the influence of their values and assumptions about participant responses and analysis (Whittemore, Chase, & Mandle, 2001). Dependability of qualitative research may be increased by ensuring compatibility between the research question, methodology, methods and findings (Lincoln & Guba, 1985). In this chapter, I have outlined an audit trail of my decisions about the methodology and methods chosen to clarify why and how I conducted the research, to enable future researchers to replicate this study (Carcary, 2009).

4.4.4 Confirmability.

Confirmability is the verification of a study’s findings by researchers using the same data and context. It demonstrates that the findings reflect the data, rather than the researcher’s views and assumptions about the research topic. In this chapter, I have outlined an audit trail of my discussion with supervisors on the changes made to data collection and analysis processes to reflect participants’ viewpoints rather than my own.

4.4.5 Reflexivity.

Reflexivity involves the researcher being aware of the factors that contribute to their research-design development and analysis of the data. Qualitative research produces knowledge that is value-laden and influenced by the interaction between researcher and participant, thus objective knowledge about a situation or social context is not possible (Braun & Clarke, 2013). Therefore, I consistently self-reflected throughout the research process to heighten personal awareness during data collection and analysis to lower the chances of my values impacting the research processes. I exemplify some of my personal reflexivity processes, below.

My academic background in criminology and psychology, and my work experiences, allowed me to focus on the social and mental health aspects of the inquiry. As an outsider to the legal profession, my perceptions about legal representation and the lawyer's role are not affected by insider legal training on best-practice legal representation. As I conducted the interviews, I reflected on the differences in my and the lawyers' backgrounds and views of the topic, which enhanced my ability to accept and think about lawyers' perspectives, as they were presented, rather than ponder about how they *should* practise.

Given my personal, academic and work background I am sensitive about human rights violations issues. The interviews with lawyers were sometimes confronting because some lawyers held legalistic viewpoints about their role and practice, while I focused on the social and empowerment aspects of legal representation. In the case that triggering information was disclosed, I journaled about my feelings and thoughts to decrease the likelihood of judgment affecting future interviews with lawyers. It also helped me be more accepting of diverse perspectives.

I was aware that my interaction with lawyers affected their comfort levels and how much information they disclosed, and that rapport would vary with each participant. I collated a brief report on my experience and perspective of the interview immediately after it was completed. I evaluated the interview and noted which questioning techniques were effective, and areas for improvement in future interviews. I also made notes of general observations about rapport and my perceptions of participant comfort levels during the interview. I was therefore able to modify my interviewing technique and style to maximise disclosure of information about the research question.

4.5 Ethical Considerations

I obtained ethical approval from the University of Auckland Human Participation Ethics Committee (UAHPEC) on April 18, 2016. Later in the year, amendments to the PIS, CF and recruitment techniques were made and approved by UAHPEC. Because this study involved lawyers' participation, approval was also received by the Committee which requested some modifications to the CF and PIS; once appropriate changes were made, the Committee approved the project.

4.5.1 Informed consent.

Participants' involvement in this research was voluntary. Lawyers were emailed with an invitation to participate in the study, and only lawyers who chose to respond were contacted with a personal request for participation. If they decided to withdraw their participation from the research, I respected their decision without objection. Interviews were audio-recorded only if the participant consented. In the PIS, participants were informed that they were not obliged to answer questions, could stop the recorder at any time during the interview, revise and retract statements from the interview transcripts and withdraw participation from the research up to September 1, 2016.

4.5.2 Confidentiality.

Maintaining confidentiality in this study was important because lawyers revealed sensitive information about inefficiencies in current mental health legal processes. This information may not have been disclosed in other circumstances, thus it was critical that I took appropriate measures to preserve the identity of the informant. I maintained participant confidentiality during all stages of the research process. I only shared the names of participants, signed CFs and interview transcripts with my research supervisors. I did not discuss information shared by the participants with anyone other than my supervisors. I did not provide the names of lawyers to the ADLS and the Waikato Bay of Plenty Branch of the New Zealand Law Society.

Only a small number of lawyers work on the legal aid Mental Health Roster in New Zealand. Thus, it is possible that participants are identifiable in research outputs, regardless of strategies to de-identify participants. I removed potential identifying details in the transcripts, such as clients' and participants' names, ethnicities and the geographic locations in which participants' practice. I gave participants the option of revising transcripts and retracting statements they felt made them identifiable up until 2 weeks after they received the transcript. Lawyers were

informed about this risk in the PIS. Out of 11 participants, only three requested their transcripts. In the research outputs, I allocated a number to participants to protect their identity. Audio recordings and transcripts were stored in a secure place and were only accessible by the researcher and supervisors. The notes, audio-recording and CFs are due to be stored securely at the University of Auckland for six years after completion of the study.

4.6 Summary

This chapter has described qualitative descriptive research design and justified why it is the optimal method to explore lawyers' experiences and perspectives of representing clients under the MHA 1992. It also described the data collection, management and analysis methods and the steps taken to ensure the study's rigour. The chapter outlined ethical approval and ethical issues. The study's findings are developed thematically and presented in the next two chapters (Chapters 5 and 6). Chapter 5 presents the themes on the core functions of legal representatives under the MHA 1992, as perceived and described by the study's participants. Chapter 6 presents findings on the barriers and facilitators lawyers experience and perceive as obstructing provisions of effective legal representation.

CHAPTER FIVE: THE ROLE OF THE MENTAL HEALTH LAWYER

The findings of this thesis are presented in Chapters 5 and 6. This chapter presents findings on the lawyer's role and the tasks they usually undertake while representing clients³ under the MHA 1992, as experienced and perceived by them. Chapter 6 presents findings on the barriers and facilitators to providing effective legal representation to clients. While Chapter 5 focuses on how lawyers perform their role *in practice* and mainly the positive aspects of legal representation, Chapter 6 highlights the challenges they experience performing this role and how they overcome the difficulties they encounter. Three main themes and multiple subthemes on the mental health lawyer's role were identified from the analysis of interview transcripts. The main themes are: i) liaising with health professionals, ii) facilitating client participation in legal processes, and iii) checking the quality of health professionals' evidence. The themes and their subthemes are illustrated in Table 4.

Table 4

Main Themes and Subthemes on the Role of the Mental Health Lawyer

Main themes	Subthemes
1. Liaising with health professionals	1. Collecting evidence 2. Developing legal arguments and tactics 3. Advocating for clients' social and treatment concerns
2. Facilitating client participation in legal processes	1. Developing rapport 2. Providing legal advice 3. Giving clients a voice
3. Checking the quality of health professionals' evidence	1. Applying the "mental disorder" test 2. Cross-examining evidence

Excerpts from the interviews are used to illustrate the themes and subthemes. Participants are identified by number to protect their identity. Some quotations have been modified slightly to

³ The term 'client' is used in the description of findings and when introducing quotes to align with ADLS's (2010) recommendation that lawyers refer to persons they are representing under the MHA 1992 as *clients* and not *patients*.

make the participants less identifiable. Care was taken, however, to ensure that the meanings of statements were not altered and are expressed in this chapter in the same context in which they were discussed by the participants. The next sections describe participants' characteristics and the three themes.

5.1 Participants' Characteristics

Participants varied in age, gender and ethnicity. Their ages ranged from 42 to 80. The sample consisted of more men (n = 8) than women (n = 3). Participants identified with two ethnicities: New Zealand European or Pākehā (n = 10) and Māori (n = 1). Participants had varying years of experience working as a lawyer, in areas other than mental health, ranging from 12 to 56 years. Participants had various legal specialisations including family, criminal, immigration and commercial law. Their mental health law experience varied from less than 1 year to 26 years. The approximate proportion of mental health law work the participants engaged in, compared to other legal work, varied from approximately 5% to over 50%.

Participants highlighted several factors which influenced their involvement and continuation in mental health law work. These included a passion for promoting the rights of vulnerable persons, a desire to give back to the community, a desire to ensure a proper system is in place to safeguard individual rights, a desire to enable clients' treatment and social concerns to be heard, and wishing to contribute to the wellbeing and recovery of mentally unwell persons. Some participants began practising in mental health law serendipitously, through criminal or family work, though they opted to continue practising in this area due to interest, even though it is not a lucrative field.

5.2 Theme 1: Liaising with Health Professionals

Theme 1 explores how the participants interact with health professionals while preparing and advocating for their clients in mental health hearing and review processes. All participants referred to their clients' notes and the discussions they have with mental health nurses and RCs about clients' circumstances, capacity, mental state and patients' rights of leave and appropriate treatment. Theme 1 is composed of three subthemes: collecting evidence, developing legal arguments and tactics, and advocating for clients' social and treatment concerns.

5.2.1 Collecting evidence.

All 11 participants described how they examine relevant paperwork, including clinical reports and hospital notes, and engage with RCs and mental health professionals as routine preparation

for legal processes. For example, four participants elucidated that they obtain clients' paperwork and usually speak to health professionals to understand their clients' behaviour and circumstances.

You look through the files, ask the right questions of the RC and there's usually two shifts of nursing staff so you speak with them both. (Lawyer 2)

I will talk to the doctor; I will talk to a number of nurses about how they [clients] are on-ward. The nurses write down the behaviour, and it's the behaviour that is the assessment of someone's mind. (Lawyer 6)

I will obtain all reports and notes on the file, I will speak with the responsible clinician and nursing staff that are dealing with that patient at any particular time. (Lawyer 10)

You review the clinical notes, you possibly speak to the clinicians. (Lawyer 9)

Several participants indicated, however, that the information obtained may negatively affect their perceptions about the credibility of clients' instructions and deter them from acting upon them. Two participants, for instance, acknowledged that they viewed their clients' instructions critically after engaging with health professionals.

You then go and look at the notes, and then you go and talk to the doctor and you hear what the family have had to say and you find that for everything the person has said about themselves and the situation, there are actually very serious reasons as to why you have to look at those with a grain of salt. (Lawyer 3)

Similarly, Lawyer 9 explained finding it difficult to accept clients' instructions at face value and relay them strongly to the judge, after having discussed them with their clinician.

If a clinician says this person has paranoid delusions, has persecutory delusions and somebody [the client] comes and tells you "well I've got microchips inserted in my wound" then that possibly means that the clinician is right. I find it quite hard where sometimes people have presentations where they claim to have been sexually abused as children in the past or in the immediate past and it's quite difficult to know what is truth and what is not. (Lawyer 9)

Some participants described these interactions with health professionals as revealing information about the seriousness of a client's mental condition, limiting their desire to advocate for their client's release. For this reason, Lawyer 5 deliberated whether to not speak to health professionals at all.

Sometimes I do; sometimes I don't [speak to RCs and nurses]The reason for that is, you have to accept that generally the medical staff are pretty well right. And so they talk to you about how right it all is and the evidence that's there. If you talk to them too much then you're too much affected by their views whereas if you're on the patient's side where the patient says "... I don't need to be here," you're trying to advocate for them and I often find for myself that the medical opinion gets in the way of that. Even if they're right, I'm here to believe my client. (Lawyer 5)

Another reason for liaison with health professionals was to verify some clients' capacity to give informed consent to CompTO hearings. Four participants corroborated clients' capacity with RCs to manage uncertainties about their ability to instruct their lawyers. Two lawyers, for instance, explain this.

And you can corroborate this [capacity to give informed consent] with any of the clinical staff and say well doctor it's my observation that so and so is still unwell. So, then even while the patient can agree to a community treatment order, I believe you've still got a duty to inform the court that there are certain aspects of their ability to give you informed consent.... You question mark it. (Lawyer 1)

Lawyer 8 spoke to clinicians to understand whether his client's mental condition impacted his or her capacity to give informed consent.

You ask the clinicians if you're under any doubt just to confirm that yes, they have insight, that their consent is informed based on no cognitive impairment, and that they are giving genuine consent. (Lawyer 8)

Many (n = 7) participants also chose to speak to health professionals to gauge clients' current mental state and behaviours to protect the clients and themselves from harm. Two participants described how this information was significant for effective pre-hearing interviews.

Lawyer 1 explains:

I always check with the nurses how is Sue or Sam today? Just really want to get a feel for the patient's wellbeing that day. Are they agitated? Are they irritable? Has there been a violent incident? Just so you know where their mental state is. Because you're going into an interview session. (Lawyer 1)

Similarly, Lawyer 7 would gauge clients' state of mind before scheduling the time of the interview.

I will check with the staff [nurses] about whether they think it's okay for me to see the person because sometimes another stranger intruding on someone is not always a positive thing for the client. (Lawyer 7)

Evaluating a client's risk of being dangerous, with RCs, impacted Lawyer 8's decision about the location of the pre-hearing interview.

I'd be very, very careful and I would probably have a discussion with a clinician about that [likelihood of client being dangerous or inappropriate] if that [meeting client at their residence] was requested by the client. If the client said "Come and see me, I want to see you." That's fine in a way, and I say "you can see me here [community mental health centre]." (Lawyer 8)

In summary, all 11 participants revealed that reference to paperwork and discussions with nurses and RCs was a significant aspect of preparation for hearings. Considering health professionals' evidence was an important way to collect information about their clients' capacity and mental state. It also allowed them to understand clients' circumstances, the credibility of some of their clients' instructions and to prepare in a manner that did not distress clients or jeopardise their own safety during pre-hearing interviews.

5.2.2 Developing legal arguments and tactics.

Three participants stated that they consulted with RCs to understand their justification for compulsory treatment. This information partially contributed to the development of rigorous legal arguments to challenge the medical professionals' assessment of mental disorder. For example, Lawyer 10 describes,

If they are opposing it then I have to prepare in consultation with the responsible clinician exactly what the grounds maybe haven't been met....I'm really representing the client. If the client doesn't want to be on an order, then I have to argue against it. (Lawyer 10)

Lawyer 6 explains that discussions with the RCs enhanced their ability to better argue for their clients' case.

Often just before a court hearing I'll question the doctor on this [changes in medications] and put them on notice effectively, why you've changed it, what's your theory, what's your treatment plan and I try and get that out of the doctor so I can echo it in court so it's very hard for a doctor to rebut that. (Lawyer 6)

Another way many (n = 8) participants supported their clients' instructions was by negotiating with RCs to adjourn CompTO hearings after section 18 reviews, where it was applicable. Adjournment negotiations were a legal tactic to avoid making an unnecessary order and successfully achieve clients' wishes without undergoing a hearing. For example, Lawyers 9 and 2 explained that they sometimes persuade RCs to adjourn CompTO hearings if existing evidence indicates that their clients' mental health is improving.

You ring them [RCs] or you talk to them and sometimes it can be helpful. I remember a case where instead of asking an order to be made, their [clients'] psychiatrist adjourned the matter because it appeared that the person was rapidly improving on medication and was then able to be released into the community or discharged into the community without the inpatient order, without any order, so that sometimes can be discussed or negotiated [by the lawyer]. (Lawyer 9)

Lawyer 2 explains how avoiding the imposition of an order through an adjournment is encouraging for the client.

A good one, for example, is that if you can convince the doctor that it's good to adjourn it [CompTO hearing] after the section 18 application process so there's no need for a compulsory treatment order to be made. That can be a wonderful outcome for a particular client, in a particular situation. (Lawyer 2)

Several participants suggested that adjournments enabled them to support their clients' case strongly. For instance, Lawyer 6 and Lawyer 10 requested adjournments in situations where they had limited time to prepare for hearings and they felt more time may enable them to strongly advocate for their clients and prevent an order being made.

If I feel that more time is needed then I will seek an adjournment for a month to make sure that an order isn't made if it can be avoided. (Lawyer 10)

Lawyer 6 explains that persuading RCs to adjourn the application for a CompTO hearing was rare but possible:

In some cases, you seek an adjournment just so you can get some more time [for preparation] but that's very rare and it's not encouraged. (Lawyer 6)

In summary, participants' consultations with RCs were important for the development of legal arguments and tactics in support of their clients' cases. They aimed to build strong lines of arguments in favour of their clients' instructions by understanding opposing evidence before hearings and presenting alternative explanations or less refutable evidence in legal processes.

The participants also employed the legal tactic of negotiating adjournments for CompTO hearings to prevent making unnecessary orders. This sometimes allowed them to achieve clients' instructions of release without needing to undergo legal processes.

5.2.3 Advocating for clients' social and treatment concerns.

Eight participants described advocating for clients' rights to appropriate treatment, and access to leave, with the clinical teams. The participants raised awareness about clients' medication, leave and treatment concerns and desires by facilitating dialogue between client and the clinical teams prior to hearings. Even though these factors are extra-legal, or topics outside the lawyer's traditional role, the participants believed promoting clients' interests and addressing their grievances might initiate improvements in their treatment and overall wellbeing. For example, Lawyer 11 does this by commencing a constructive discussion between client and treatment team before hearings.

If the client's happy for me to, then I will engage with the treatment team and more often than not, I think it's good to have that engagement with the client present because they're hearing you raising issues on their behalf. That could be anything from housing to medication to study....So there's a wide range of things and I don't think that you should say well, because this aspect of the treatment plan is a little bit outside of the ordinary that we shouldn't raise it, because if it's part of the client achieving a high quality of life then you know, it's worth raising. (Lawyer 11)

Lawyer 2 promoted changes in clients' medication through dialogue with the RC.

In terms of whether the medication is right or its delivery, some people say oh I'd have the injection rather than pills. What I can do is try and facilitate a discussion, say to the doctor oh why is this being done? (Lawyer 2)

Several participants also advocated for extra-legal factors by minimising miscommunications between clients and their treatment teams by acting as a conduit for information between both parties. For example, Lawyer 5 clarified existing treatment and leave plans to an inpatient client to inform them about the treatment that they will undergo.

Often, they feel that they may hardly ever see the doctor. And I think when they do see the doctor they possibly don't understand where it's going. If you have a section 16 review you can say to the doctor, "look what's the plan for him or her?", "how long do you expect them to be here?", "has there been any improvement?", "can the person

get out daily?”, “when are you looking at overnight leave?” That sort of thing. (Lawyer 5)

Some of the participants advocated for clients by addressing the gaps in their treatment teams' knowledge about their client prior to or during legal processes. Three participants explained the benefits of raising awareness among treatment teams about clients' social, medication and treatment concerns and wishes.

Or they [clients] might say “well look I’m very unhappy with the medication, there’s all these side-effects” and that’s sometimes something that I bring to the judge’s attention because it’s quite helpful to focus the clinician’s minds on these things. (Lawyer 9)

Lawyer 10 discussed the side-effects of medication on their clients to inform the RC about clients' dissatisfaction with their current treatment plans.

If someone's telling me, they've put on far too much weight on the medication, something like that, I will certainly go tell the doctor that. Or if someone's feeling sleepy all the time that they can't function properly because they feel the dose is too high, I will talk to the doctor about that. It's not something the judge necessarily needs to know about but I think it's important to deliver those instructions or that advice to the team. (Lawyer 10)

For Lawyer 11, it was also important to discuss a client's desire to be treated in the community.

If my client is happy for me to then I will put the client's position to the doctor or nurse before the hearing and see whether we can achieve what the client is asking for. So quite often that might involve the client wanting to be on a community treatment order rather than having a continuation of hospital care as an inpatient under section 30. It may involve the client says "look, I had really bad reaction to this particular drug, I used to get toxic on lithium," so we'll go and talk to them about that and look at alternative mood stabilisers and so it really depends case-to-case. (Lawyer 11)

In summary, the participants promoted changes in clients' conditions (including discharge and leave), treatment plans, dosage and type of medications, as per clients' instructions, by facilitating a conversation and improving communication between clients and the treatment teams. Clients' knowledge gaps about the management of their assessment and treatment were addressed by explaining the plan that was in place for them. The participants also relayed clients' grievances to the treatment teams and advocated for the changes that they desired. This

could demonstrate to the teams how to cater to clients' needs best and improve their quality of life.

Theme 1 explored participants' liaison with health professionals, mainly during preparation for legal processes and pre-hearing advocacy stages. This interaction was identified as an important advocacy stage during which they collected evidence about their clients, developed legal arguments and tactics, and promoted clients' social and treatment concerns and rights. Some participants also contributed to the clinical teams' knowledge about clients' desires, needs and rights by facilitating a discussion and filling in communication gaps between both parties, despite the concerns being of a non-legal nature. It helped clinicians to understand and meet the clients' needs for the duration of their compulsory treatment.

5.3 Theme 2: Facilitating Client Participation in Legal Processes

All 11 participants explained that they facilitate clients' participation in legal processes, thereby enabling them to contribute to the clinical and legal decisions made about them. Central to this theme was the interaction that occurred between the client and lawyer. Three subthemes resulted from the analysis: developing rapport, providing legal advice, and giving clients a voice.

5.3.1 Developing rapport.

Almost all (n = 9) participants spoke of the importance of developing a trusting relationship with their clients. In cases where participants had represented clients previously, it was easier to develop rapport due to pre-established relationships. Several participants highlight this fact.

Obviously if they've had previous counsel, that previous counsel, if they're available, would be expected to look after them. And the reasons for that are obvious, that's someone they've already met. There's hopefully an established relationship and better rapport, rather than with someone they haven't met before. (Lawyer 2)

Lawyer 7 suggested that a special lawyer-client relationship enhances legal advocacy:

It allows for better representation of our clients because it allows for that personal relationship that you have to have with a client in the normal course of things. (Lawyer 7)

Developing rapport and building trust with new clients also required empathy, patience, sensitivity and respect. Several participants, for example, demonstrated empathy and sensitivity towards clients' experiences of illness, treatment and compulsion.

We're dealing with clients who have often had trust broken, they have at one time or another in their life been very vulnerable and have been exploited. They are often sharing with us things that are extremely close to their heart that they may not have ever disclosed to anyone else. You can't take that lightly. (Lawyer 11)

I'm very conscious that I'm a stranger coming in and talking to them, at that time they don't know me. I'm part of a situation which is often not or is ever one of their choosing. No one chooses to be unwell. But things could have gone very badly for them. And if they've been admitted and if they're in an acute ward it can be quite terrifying for them. And to be told that they've got to recount how bad things are for them at the moment with another stranger can be very upsetting. (Lawyer 2)

Lawyer 3 discussed respect:

I think whether it's [the hearing's] opposed or not, it's an opportunity to build a little bit of rapport. By the time the hearing has ended, the person has just had a chance to feel good about themselves, really feel heard, to have respect and understanding of authority. (Lawyer 3)

Several participants exhibited these values in their practice to develop a trusting relationship and maximise disclosure of information. Lawyers 6 and 2 explained the importance of adequate timing.

You've got to spend time, be sensitive to them. One of the clients...she's very delicate, has a depressive illness, doesn't trust anybody and so it's a matter of time so you become a familiar face. (Lawyer 6)

Generally, I talk to clients and make contact with them by phone just to let them know I'm coming. Because you want to make sure it's as amenable to them as it can be.... It's better that with any client that you put them in the best position that you can so that they can hopefully built a rapport and trust you because what we're dealing with is pretty crucial and fundamental in terms of them and their situation. (Lawyer 2)

Several participants mentioned to clients that they are independent of the mental health service to increase clients' confidence in them. For example, Lawyer 10 explained.

When we meet the client the first time we make it very clear that we are not associated with the health board, we're completely independent. Sometimes I think that we as lawyers may be the only people that they feel that they can confide in. (Lawyer 10)

In summary, the participants recognised the importance of building positive relationships to maximise disclosure of information, improve the quality of legal representation and enhance the protection of patients' rights. They were empathetic, sensitive to clients' circumstances and current feelings, and respectful to them, to increase their dignity and maximise the development of rapport and trust. The participants thought about how their clients were feeling and adjusted their practice accordingly to ensure clients were in a good emotional and physical space for an effective pre-hearing interview.

5.3.2 Providing legal advice.

Eight participants mentioned that they provide legal advice to clients so that they understand the purpose and limits of the legal processes, and can decide for themselves the best course of action for them. The legal advice they provided includes explaining the purpose and function of mental health hearing and review processes, the likelihood of release, the client's legal rights and advice about when they should review their compulsory status. For example, three participants explained the style and jurisdictional parameters of legal processes so clients would have realistic expectations from their lawyers and the likely legal outcomes of legal processes.

You explain to them how it [legal process] works. That it is not adversarial. It's more like a big give and take discussion between a judge, a doctor, some nurses, some keyworkers and some lawyers. But there are some really important questions and answers that have to be made. The big bit of it is that it's all down to legal process.
(Lawyer 1)

For Lawyer 8, it was important to explain the legal criteria and consequences of being subject to compulsory treatment.

There's a lot of these issues that I have to explain, not just the section 2 definition of mental disorder but what do you understand will happen, when are you likely to be released, or have a transfer of care back to a community and what will happen after that. (Lawyer 8)

In addition, several participants suggested that the information they explain to clients about their legal rights may empower them to exercise them in the future, especially their rights to review. Two participants explain this:

One of the preliminary things I do is that I make sure that they understand what the process is about, what the doctor's applying for, what does that mean, what can they

do, that they have the right to say “no, I disagree,” that’s a very important thing of course. Because to me using the Mental Health Act isn’t simply rubber stamping what the doctor says they want. I’m very much aware in terms of public law, it’s the power of the state against the individual. So clients’ rights and their understanding becomes more important. (Lawyer 7)

Lawyer 8 suggests,

And just keep them confident that their legal rights are going to be recognised, if not now, then at a later date. Plus, to explain to them as well, and often this arises when someone goes under an indefinite order that they will have access through the referral to the district inspector to file a section 79 review if they choose to. Other things arise though, you know, their right to seek second opinions regarding the medication, things like that. (Lawyer 8)

Several participants advised clients to withdraw review applications if they were unlikely to be released. For example, Lawyer 2 elucidated that he advises this if existing evidence portrays clients unfavourably.

For example, if they’ve been recently admitted, they’re extremely unwell, then part of the advice is, look given what you’ve been alleged to have done recently and the concerns of the medical staff, it’s unlikely if you’ve tried to kill someone that you’re going to be released.....so this is going to be a difficult application to bring. Is it something that perhaps can wait? (Lawyer 2)

Other participants advised clients to withdraw review applications if they were responding to their treatment well. For example, Lawyer 5 explained how advice about withdrawing a section 16 review application achieved successful legal and therapeutic outcomes for his client at a later date.

We went through a section 16 hearing, which turned into...we’ll discuss what their plan is, let’s work on their plan, don’t worry about you trying to get out of here. And during the course of that hearing, the doctors expressed certain opinions that were very encouraging for him. So ultimately, I told my guy to withdraw the section 16 application towards the end of the hearing, to say look, listening to what the doctors say, you’ve got a chance of being out of here relatively quickly under a community treatment order....That worked quite well. By that time [of the CompTO application] he was back home and doing quite well. So there’s that situation that was quite good. (Lawyer 5)

Some of the participants claimed that legal advice may increase client insight. For example, Lawyer 2 believed that an independent view on treatment may increase understanding about their illness, and the need for treatment, and help them consolidate and accept treatment.

If there is a situation whereby the client understands the process, understands why what's happening is happening, and through that greater understanding appreciates and becomes more accepting of it then I take that as a plus too. If the client can say, I know what test I am going through, why the medication, why there are all these blood tests, these injections. The psychiatrist could well have explained it to the person as best as they could but the person's just unwell and they could take on 80% of it, if not 100%. And through the process of us being involved, and maybe it's a different voice, but just hearing the same information whatever reason it sticks that time, then I think it's a good bi-product of the involvement we have. (Lawyer 2)

In summary, participants believed that providing legal advice was an important aspect of their role to improve clients' understanding about legal processes, their rights and the consequences of compulsory treatment. Legal advice helped to implant, in them, realistic expectations about the outcomes of hearings. Participants explained to clients the purpose and parameters of legal processes, and their legal rights, such as a second opinion by a psychiatrist, and their right to apply to the MHRT to review their legal status and to address treatment concerns with DIs. This may have empowered them to make a choice about exercising their rights at a future date or to avoid the distress of hearings. The legal advice, lawyers claimed, is important as it may also partially support the clinicians' aims by increasing insight which is understanding about how they can recover or improve their health.

5.3.3 Giving clients a voice.

The participants stated that giving clients a voice was important to the quality of legal representation because it ensured clients' views were heard. All participants strove to give clients a voice and facilitate their participation in legal processes to ensure their concerns and wishes were communicated to the courts and tribunals. They enabled their clients to be heard by indirectly relaying their views to courts and tribunals or by encouraging clients to participate in legal processes and state their views themselves. For example, Lawyer 9 explains,

Effective legal representation is to ensure that the client's concern is heard by the judge effectively. (Lawyer 9)

Giving voice to clients sometimes had immediate benefits of a non-legal nature. For example, Lawyer 3 provided an example of how facilitating a client's participation in the legal process effected material changes in her social situation, and access to leave rights, with the help of the judge.

She [the client] just said, "Your honour, I just want to go and get some cigarettes and go to the bank before it closes at 4 o'clock." Even though it wasn't what the purpose of the hearing was, the judge said to the psychiatrist - "Surely this is possible." They kind of were held accountable for practicalities that would normally be outside the need for a court hearing. She left really happy because they said that they would go get cigarettes with her. She didn't get to be released but she got what she wanted, which was the cigarettes and going to the bank. (Lawyer 3)

Some participants also believed that the opportunity to be heard was therapeutic in itself. Two participants explained the affirmative value of a client seeing someone argue their case and giving them an opportunity to vent.

I think really successful representation depends on the person taking ownership by committing something to writing which we could give the judge and having the chance to vent or say something. (Lawyer 3)

But then the next level of achievement is to simply ensure that the client sees that somebody's tried to argue their case, that they've had their case put before a judge and that there has been a due process to ensure that they are being heard. (Lawyer 9)

Some participants explained the potential of legal representation to positively impact on their clients' perceptions about the legal processes and their satisfaction with it. Lawyer 5 elucidated,

Patients are quite funny in that sense. They might get all fired up for the hearing "I don't want to be here, we're fighting this order." So it's an inpatient hearing and we lose the order and then they just walk off quite happily. (Lawyer 5)

I attempted to battle for her to come off the Act. At the end of the day she didn't succeed but she felt satisfied that she had a good hearing, that her concerns were heard. (Lawyer 10)

However, not all clients reaped the therapeutic benefits of being heard. Lawyer 9 stated:

To be honest I've had both experiences. My first client, she had two different judges for two different hearings. One judge was very efficient, legal, didn't really engage with her much. She was unhappy with it, she didn't get the order she wanted. She had

another judge who was absolutely lovely, very caring, listening carefully, giving everybody a chance to be heard. She was equally unimpressed; it didn't matter to her. It matters to some clients; it doesn't matter to other clients. (Lawyer 9)

Lawyer 5 and Lawyer 10, thus explained that clients whose views were heard felt more satisfied about the legal processes although they were not successfully released from compulsory treatment. However, Lawyer 9 indicated that the positive ramifications of being heard, on clients' views of legal processes, is individualised and client-dependant.

Almost all (n = 8) participants said that they gave voice to their clients when they incorporated the instructions and explanations of their behaviours into the cross-examination of evidence and questioning of mental health professionals. Lawyer 2 explains,

Cross-examination of the mental health professionals, we need to do that, we need to put our client's case. And you know, the skill I guess is trying to ask the questions, to put the strengths your client has, which you're relying on. (Lawyer 2)

Lawyer 3 gave an example of representing a client's view:

But her version is that she just caught a taxi around to see her family, they weren't home, she was calling out, she knocked on the door and wanted to say hi, and that was all. But someone from within the house, called the police and she was taken to the mental health unit. Clearly, something has gone down that made it important to involve police but if in fact her version of events is true and that's what brought her into the mental health unit. (Lawyer 3)

Cross-examination based on clients' instruction was one of the main ways they supported clients' cases. This could enlighten the treatment team as to the clients' interpretation of their behaviour and circumstances and help the courts and tribunals to consider these views in decision-making. Lawyer 11 stated,

So often good cross-examination based on client instruction assists the court with understanding the competing positions and it also enlightens everyone if you ask the right questions. Because the real struggle for clients is that the illness can often manifest itself in a way that they believe is absolutely real. So you often hear of clients who say "no, no, no, I don't hear voices, those people who drove past me in the car that day, they were shouting at me." It could either be people shouting from a car or it's so real to the client that the derogatory voices they're hearing, which they think come from the car so external to them, are in fact a manifestation of illness. (Lawyer 11)

In short, the participants described that giving clients a voice was an important aspect of their role. They outlined the advantages of being heard, including the opportunity to vent, satisfaction with legal processes and have their viewpoint heard by judges, tribunals and the treating teams. Incorporating clients' instruction to cross-examine evidence was an effective, and often the only, way to allow clients' perspectives to be heard while challenging grounds for compulsion.

Theme 2 explored how the participants facilitated client involvement in legal processes. The interactions between the lawyer and client are central to this theme. Three subthemes resulted from the analysis: development of rapport and trust to maximise disclosure of instruction; provisions of legal advice to empower clients to understand their condition, compulsory treatment and make choices about when to exercise their right to review; and giving clients a voice either through direct or indirect participation in legal processes. The facilitation of clients' participation in hearings allows them to make decisions about their compulsory treatment. It also allows their evidence, information and opinions to be considered by legal and clinical decision-makers. Such considerations potentially enable them to make and contribute to the decision made about them in this context.

5.4 Theme 3: Checking the Quality of Health Professionals' Evidence

Theme 3 explores how participants check the accuracy of the health professionals' evidence that justifies clients' need for compulsion. They test the quality of their evidence by applying mental disorder criteria to clients' circumstances and cross-examining health professionals and family members to ensure detention is lawful and not due to medical or benevolent reasons. Central to this theme, therefore, is participants' engagement with the evidence for and against their clients' need for compulsory treatment. Two subthemes resulted from the analysis: applying the "mental disorder" test and cross-examining evidence.

5.4.1 Applying the mental disorder test.

Seven participants stated that they apply mental disorder criteria by looking for discrepancies between RCs' and clients' views about how the client has met these criteria. One way in which they assess for mental disorder is by obtaining clients' opinions and agreement or disagreement with the RC's opinion. Two participants, for instance, demonstrate how they endeavour to discover their clients' views of the clinical opinion when checking the first limb of mental disorder.

I ask them [clients] whether they accept the diagnosis the doctor has made for "mental disorder." So the doctor might say the person has schizo-affective disorder, where a client will accept they actually have a mood disorder as defined under the law. So, if it's a mood disorder we can assess in legal criteria, yes you have a mood that goes up and down, that's way beyond normal, yes that needs to have some kind of treatment. So, I'll often just cross out one or the other and I'll put "yes" if they agree to it and "no" if they disagree. (Lawyer 6)

Lawyer 11 explains that this allows clients to comment on the clinician's opinion about their condition and enables them to check how accurate the clinician's assessment of mental disorder is.

When I'm interviewing the client, I try to make it really clear to them that I'm not interested in what the clinical opinion is, I already know that. What I want to know is what you think? So do you think you've got an illness? How did that start? How are you going now?... you can get very good detail from a client and then that enables me to assess the client's view of diagnosis and whether there's a qualifying illness in terms of limb 1, what they think about the extent of any risk and how they manage and then compare that to the clinical opinion. (Lawyer 11)

Several participants described that a similar procedure was followed when checking the second limb of the mental disorder criteria. Two participants explain this,

And I'll look at the medical notes for that but I will talk to the client: do you accept the risk assessment? The doctors say you're at risk to yourself or to others, and the client will inevitably say no I'm not at risk. (Lawyer 6)

Broadly speaking you meet with the client, you understand what their position is...you get instructions on the two limbs of the Mental Health Act – what do they not accept, do they not accept that they are mentally disordered? Do they not accept that they're a risk to themselves or others? – and then the preparation depends a little bit on what they challenge and what the basis is. (Lawyer 9)

Some of the participants stated that when checking for weaknesses in the second limb of mental disorder they reviewed clients' paperwork to check that the RC had provided sufficient evidence to support his or her opinion. Additionally, they applied the behavioural evidence in their clients' notes to check if the second limb of mental disorder criteria was met. For example, one participant describes that her client's notes suggested that she was not dangerous.

Her notes don't seem to hold anything...that you couldn't explain logically. Maybe she isn't a danger to herself or others, maybe she's not as mentally disordered as they said, so it's worth arguing. (Lawyer 3)

Similarly, for Lawyer 2, referring to clients' evidence allows him to check whether the second limb is met and critique the accuracy of the clinician's assessment of mental disorder criteria.

There are two limbs to the test and because someone suffers from a delusion it doesn't necessarily mean that they're unable to look after themselves or be a danger to anyone. Whereas the person [clinicians] may have in good faith thought that this person's unwell and they may need to be treated, that's what led to the admission. There may be evidence there to suggest they don't meet the second limb, they haven't reached the threshold for compulsory treatment. (Lawyer 2)

In summary, the participants checked whether their client met the legal criteria for mental disorder by looking for differences between RCs' and clients' opinions about their mental state. The participants described similar procedures of referring to hospital evidence and speaking with clients to check for inaccuracies in the clinicians' assessment of both limbs of the legal criteria for compulsory treatment. However, they stated that reviewing the second limb was often easier because they could critique the evidence pointing towards their clients' dangerousness in addition to obtaining their clients' viewpoints on their hospital record.

5.4.2 Cross-examining evidence.

All (n = 11) participants explained that cross-examination of RC and family members during legal processes was necessary to reveal inaccuracies in health professionals' evidence justifying their clients' compulsion, and to prevent misappropriation of the MHA 1992. For some participants, cross-examination allowed them to affirm their clients' cases, as explained by two participants.

Our job is to make sure the judge is aware that there is evidence in favour of our client's view and belief. (Lawyer 3)

For Lawyer 2, cross-examination was important to present clients' evidence to courts and tribunals so they can consider all the evidence, to make an informed decision about their client.

Cross-examination's a way of putting your client's case, putting the evidence there to make sure that the decision maker has given all the relevant evidence to the actual court or the tribunal. As long as the decision maker has all the evidence and it's helpful to what your client wants then that's absolutely crucial. (Lawyer 2)

Several participants explained that they also cross-examine RCs when they believe that the hospital's evidence is not up to standard. Two participants explain this.

I find there's often a problem with a nurse who hasn't seen the client before, which is far from satisfactory. (Lawyer 8)

For Lawyer 6, witnesses who have a fixed outcome in mind that does not actually reflect his client's actual circumstances, was problematic.

If a lot of their variables that they have used are based on second- or third-hand, hearsay, or from family members who've got a predetermined outcome in mind and that can be quite destructive. It's very important that the doctors reach their own conclusion based on a process that is quite transparent. (Lawyer 6)

For five participants, cross-examination exposed that the RC's evidence did not meet legal criteria for compulsion. The participants explained that cross-examination may also secure clients' successful release from compulsory treatment. For example, as Lawyer 4 and 8 describe,

I have caught some doctors out and I feel good about that because that's making sure the system works....The doctor was asserting that if the patient was released to go home, well it might cause a divorce....Personal relationships are what they are, nothing to do with the Mental Health Act. And the judge agreed with me and let the patient out. Wrong criteria. (Lawyer 4)

Lawyer 8 explained that cross-examination ensured that clients are not detained because of their cultural and religious beliefs and lifestyle choices.

It's all evidence based but the doctors can be challenged on the issue of whether or not your client's making valid lifestyle choices based on their religious or cultural beliefs. (Lawyer 8)

Several participants mentioned that cross-examination may also be an effective tool to prevent containment of risky populations or the protection of mentally unwell persons. They explained that they had held risk-averse, conservative and paternalistic RCs accountable due to their damage to clients' liberty. Three participants describe this.

I might have had two or three successes in my time over the past 13 years. And usually it's very clear that someone is not needing to be on the Act. (Lawyer 10)

And the doctor doesn't think they have that [a mental disorder] but they're keeping them in there just in case something goes wrong and they get in trouble with their peers

and higher-ups so often a very risk-averse conservative opinion is made at the detriment of a client's freedom. (Lawyer 6)

They [RC's] often do get broadly concerned about ongoing issues in young people, for instance, their failure at university and this sort of thing, you know they can be overly paternalistic. And I think they've got to be reminded of that. (Lawyer 8)

Eight participants described using an array of techniques to cross-examine mental health professionals, the reliability of health professionals' evidence about clients' dangerous behaviour and the source of the evidence. For example, Lawyer 2 and Lawyer 7 presented alternative explanations for clients' "dangerous" behaviour, other than mental abnormality, to challenge the correctness of the hospital's evidence.

Or it could be from another neighbour that they talk to plants for example, or that they pray loudly. The fact that they pray loudly or talk to God does not necessarily mean that they suffer from delusions. (Lawyer 2)

So you say that Mr. so and so has threatened his neighbours and is throwing stuff and he's done this and he's done that to the neighbours. Where did you get your evidence from? and it might be that it's third-hand from the neighbour. So for me, here's something I can use because I can say hang on, how do you know that this behaviour of my client is caused by a mental health disorder? (Lawyer 7)

Conversely, some of the other participants adopted a sensitive, rather than confrontational, approach to cross-examination. Sensitive yet rigorous cross-examination was important to the participants to respect the professional integrity of psychiatrists. For example, Lawyer 1 explains,

You've got to test the evidence...in a non-confrontational but a very affirmative and insistent way. (Lawyer 1)

Lawyer 6 felt more comfortable cross-examining RCs delicately in a medical-dominated field.

It's not the lawyer's role to determine an outcome and have an adversarial contest. However, we are entitled to ask the doctors some question that are relevant and those areas of cross-examination have to be done delicately because they are an expert and a lawyer's just a lawyer, not medically experienced. (Lawyer 6)

Some participants cross-examined family members and clinicians tactfully so as not to distress clients during legal processes or aggravate their relationship with families or treating teams.

Lawyer 8 states:

It's very difficult when the original evidence comes from caring supportive family members and you have to raise these issues about the concerns that are expressed in the reports. That can create a great deal of tension between the applicant and their family members and also between the patient and the treatment team. I can aggravate those very tense relationships and I'm very mindful of that. I exercise a great deal of discretion in the way I introduce the applicant to the information ... The judge will hear the evidence in the absence of the patient, the patient will just be asked to go outside of the hearing room. I can cross-examine them on the quality of their evidence based on the information that I've received from my client. (Lawyer 8)

Some participants were sensitive to the level of illness clients exhibited, adjusting cross-examination accordingly. In such situations, they may also limit cross-examination if they notice that clients are becoming distressed during hearings. Lawyer 7 relates,

But that will be in situations where the client is really clearly unwell, where continuing cross-examination is clearly not in their best interests... so I don't think it's negligent practice on my part to do that. I just think that sometimes it's appropriate that you don't pursue cross-examination as you might otherwise do. (Lawyer 7)

In summary, participants cross-examined hospital and family members' evidence to check the accuracy of the hospital's evidence justifying clients' compulsion and to put forward evidence that supports clients' views. Rigorous but sensitive challenging of evidence was part of the process of ensuring that clients' liberty is deprived for legal rather than paternalistic or public-protection reasons. These techniques aimed to hold them accountable for their clients' deprivation of liberty, yet respect RCs' professional integrity; to prevent harm to RC-client relationships or client-family relationships; and to not negatively impact clients' wellbeing.

Theme 3 explored the lawyer's role in checking the quality of health professionals' evidence and its alignment with the legal criteria for compulsion. Engagement with the evidence for and against clients' compulsion was central to this theme. Participants checked for discrepancies between their own and RCs' applications of the mental disorder criteria, and cross-examined health professionals' evidence to ensure that persons were detained for accurate legal, rather than medical or social, reasons. The participants described how they upheld clients' liberty

rights but also supported their clients' recovery by checking the accuracy of the evidence that supported clients' compulsion and preventing disruption to their therapeutic goals and relationships.

5.5 Summary

This chapter has presented the study's findings on the core functions of the mental health lawyer and participants' beliefs about effective legal representation and associated practices. The three main functions of the mental health lawyer are: liaising with health professionals, facilitating client participation in legal processes, and checking the quality of health professionals' evidence.

Participants described consulting with RCs and nurses to prepare for hearings, develop legal arguments and tactics to support clients' cases, and advocate for their clients' legal and social concerns and rights. Facilitating client participation in legal processes involves developing rapport, providing legal advice, and allowing them to be heard and to contribute to clinicians' and decision-makers' understanding of clients' desires and needs for their wellbeing. Participants also check for the accuracy of the hospital's evidence by noting inconsistencies in RCs' assessment of mental disorder criteria and by cross-examining evidence in hearings to ensure only adequate quality evidence and correct criteria is used to justify compulsory treatment. A commonality between the three themes is that lawyers attempted to decrease the power imbalance between client and treatment team, and client and courts and tribunals. This lowering of power imbalances results from discussing clients' issues with the treatment teams, understanding and promoting clients' views and increasing their knowledge about their legal rights and processes, and checking health professionals' evidence is in alignments with their clients' instructions and the legal criteria for compulsory treatment. They also involve clients in decision-making by enlightening legal decision-makers and clinical teams about clients' desires and needs, before and during legal processes.

The next chapter presents findings on the barriers and facilitators participants experience when performing the role of the mental health lawyer. The chapter focuses mainly on the dilemmas and challenges they experience. It also touches on how they manage these challenges to improve their quality of legal representation.

CHAPTER SIX: BARRIERS AND FACILITATORS TO EFFECTIVE LEGAL REPRESENTATION

The previous chapter presented three themes about the lawyer’s core functions under the MHA 1992. This chapter presents findings on the participants’ experiences of the barriers and facilitators to effective legal representation of mental health patients. The findings draw from the same dataset of semi-structured interviews with 11 Auckland and Waikato mental health lawyers. Themes 4 and 5 are presented below, they are, i) dilemmas and ethical challenges, and ii) barriers and facilitators to effective legal representation. Multiple subthemes resulted from analysis of the data. Table 5 details the themes and subthemes, followed by the narrative presentation of these themes across two sections.

Table 5

Main Themes and Subthemes on the Barriers and Facilitators to Effective Legal Representation

<i>Main themes</i>	<i>Subthemes</i>
4. Dilemmas and ethical challenges	<ol style="list-style-type: none"> 1. Balancing civil liberties with therapeutic needs and relationships 2. Assessing clients’ capacity or incapacity to consent to CompTO hearings 3. Personal safety versus obtaining clients’ instructions confidentially
5. Barriers and facilitators to effective legal representation	<ol style="list-style-type: none"> 1. Systematic barriers and facilitators <ul style="list-style-type: none"> • Hospital resources • Training 2. Practical barriers and facilitators <ul style="list-style-type: none"> • Communication difficulties • Evidence

6.1 Theme Four: Dilemmas and Ethical Challenges

Theme four describes the dilemmas and ethical challenges the study’s participants experienced while preparing and advocating for clients in mental health hearing and review processes.

Almost all (n = 9) participants explained that they often find themselves in situations in which they are required to make difficult decisions about whether to act in clients' best interests or provide vigorous advocacy in favour of their instructions. Participants described three such challenging situations. Firstly, they emphasised the challenges of balancing clients' civil liberties with their treatment needs. Secondly, participants found it difficult to determine whether their clients have or do not have the "capacity to consent" to CompTO hearings and to subsequently presenting evidence about this issue to the court. Thirdly, participants found it challenging to determine whether it would risk personal safety to meet clients – especially clients who live in the community - confidentially.

6.1.1 Situation one: Balancing civil liberties with therapeutic needs and relationships.

Many participants (n = 6) described finding it difficult to balance their clients' civil liberties with their therapeutic needs when it was evident that they were acutely unwell, most evidence about them was unfavourable, and where fighting for their release would be detrimental to their therapeutic goals and relationships. Role ambiguity featured, therefore, in the participants' daily practices as a mental health lawyer. For example, three participants elucidated that while in theory their role was to act on their clients' instructions, sometimes acting in their "best interests" was more ethical in practice.

Lawyer 7 explained,

There are times when I have an internal tussle with myself about the clients' best interests as opposed to their instructions, what am I here for? Over time I think I don't worry about it as much as I used to because under the Mental Health Act you're acting on your client's instructions, same rules apply, same ethical and legal requirements. And that was my focus in the early days but as time goes on, I think, okay my client's telling me this but actually this is not in his best interests. (Lawyer 7)

Lawyer 3 also talked about having to "steer a line" between advocacy and supporting therapeutic goals and relationships:

I do have to steer a line between encouraging therapeutic relationships [client relationship with treatment teams], which is that if she's clearly unwell and if her notes dictate and her family are afraid of her, then it's better to push her in that direction and support her in understanding that she is mentally unwell and people are trying to help her rather than pushing and pushing to get her off the Act when that might not

assist with her wellness. So it's really hard to do your job as a lawyer and follow the clients' instructions AND promote the therapeutic relationship. (Lawyer 3)

Lawyer 10 viewed legal representation in the mental health law context as a balancing act between individual rights to autonomy, treatment and public protection.

I think it's difficult to represent someone when they perhaps are just going with the flow for want of a better phrase. They have been in this system, been mentally unwell since their teenage years and this is just a ride for them and they are required to be on meds [sic] probably for the rest of their lives. But I think we as a society need to look after these people for their sake and for the sake of the rest of people in the community because they sometimes think some crazy thoughts when they're unwell. (Lawyer 10)

Some of the participants, therefore, believed it was better to act in clients' best interests rather than on their instructions to support their recovery and public-safety needs.

The role ambiguity participants faced led many (n = 7) of them to advocate for clients strategically. They described sometimes weakening advocacy or acting on their views of clients' best interests to prevent disruption to client wellbeing, therapeutic goals and relationships. For example, three participants performed "limited cross-examination" in "defended" hearings, so as not to trigger client distress.

And it might be that in a defended hearing, depending on the circumstances, there are times when I will do limited cross-examination of the doctors. Occasionally there are circumstances where I don't do any cross-examination at all, and that could be a dangerous thing for a lawyer to do. But there have clearly been times when in a defended hearing the client is sitting there listening to the psychiatrist pick apart their lives in detail and all of these terrible things that have happened to them - sometimes that is more distressing for a client than anything. So sometimes I choose not to go there simply because I know that that's the effect it's going to have on this person. Sometimes I'll just say to a judge, "I have no questions" even though it's a defended hearing. (Lawyer 7)

Lawyer 1 occasionally followed legal duties selectively to achieve therapeutic outcomes for his client:

So you ask yourself, have I really discharged my legal duties? But have I made this process as undamaging or therapeutic as possible? So you're not engaging the client, you're not slamming them, you're not abusing, you're not injecting, you're not putting

anxiety, doubt or anything that's debilitating [to the client], not introducing that into the process. You're always looking for solutions and optimised outcomes. (Lawyer 1)

For Lawyer 9, it was important to follow clients' instructions diplomatically to not undermine their relationship with clinicians.

The challenge I experience is that you've got to forensically assess the strength of the evidence but at the same time you also don't want to undermine the relationship between the clinician and the patient. And often your patient says, "this is my instruction to you" and you can see they are completely off the rocker. (Lawyer 9)

For participants, limited cross-examination and tactical advocacy was important to alleviate distress, prevent disruption to therapeutic goals and relationship and facilitate positive outcomes.

A desire to maintain professional integrity also shaped the participants' practices. Some of them mentioned their need to protect their own, clinicians' and other professionals' reputations when representing clients' interests. In some situations, they chose not to "blindly follow" their client's instructions if they seemed illogical.

Theoretically if I'm acting for a client who doesn't want the order made, who opposes it [a CompTO], I'm trying to ensure that all views are put before the judge. But I can't allow myself to be made an idiot of because the judge will be dismissive. If I came in with crazy reasons why people shouldn't be in there, I'd be dismissed. I'd also have to bring in some judgment to the situation. (Lawyer 4)

Similarly, Lawyer 1 explained the importance of not deceiving the court:

So, when somebody quite frankly just rejects everything [legal advice], you've got to take it at face value and stay on instructions. You try and find an avenue that has integrity that's supported by evidence that you can responsibly present to the court without being stupid about it. You know you can't run spurious or disingenuous arguments. (Lawyer 1)

For Lawyer 9, it was important to not undermine psychiatrists' views:

You've got a careful and sensible psychiatrist and you don't want to be seen to attack them [by cross-examining and questioning psychiatrists in support of clients' instruction]. So I think it's sort of a difficult balance to strike. (Lawyer 9)

The participants stated that advocating for a client's release may sometimes be irresponsible, harm their reputation or belittle psychiatrists. Therefore, they believed it was important to bring all views to the judge to enable a decision to be made in their clients' interests rather than one that was detrimental to their health.

In summary, participants highlighted the ethical challenges they experienced balancing clients' civil liberties with therapeutic goals and relationships. They often provided best-interest advocacy rather than fully support their clients' instructions. The participants were largely concerned that blindly following clients' instructions to be released and automatically adopting vigorous advocacy techniques may be detrimental to their treatment, relationships, wellbeing and the safety of others. Moreover, participants made judgments about acting in clients' best interests to maintain professional reputations and ongoing positive working relationships with clinicians.

6.1.2 Situation two: Assessing clients' capacity or incapacity to consent to CompTO hearings.

Many participants (n = 7) stated that establishing whether clients have or do not have the capacity to consent to CompTO hearings is arduous. They explained that issues of capacity to consent are only relevant in CompTO hearings. For example, Lawyer 2 illustrated that if there are ambiguities in clients' capacity to consent, participants usually assumed a "no consent" hearing:

If we're unable to ascertain whether they support - this is not about the section 16 application - but for a compulsory treatment order application, if we're unsure of when they consent or not, then we treat it as not being consented to. (Lawyer 2)

Some of the participants explained the situations in which they had doubts about clients' capacity for a consent hearing.

I think when it's really clear to you that they're still currently psychotic. In other words, they're responding to non-apparent stimuli, they're talking in gibberish, out loud, laughing. (Lawyer 1)

I've had clients who I've been very sure that they haven't really taken anything on board because of the level of medication they've received, because of how unwell they are. (Lawyer 2)

Are they aware that they're agreeing to inpatient treatment that could be of up to 6 months' duration? Because usually it's not.... But you've got to be able to say to the judge, yes, I believe their consent is informed. (Lawyer 8)

The participants described indicators of limited or no capacity including irrational behaviours, incoherent instructions and an inability to understand legal advice and the consequences of being subject to a CompTO on their liberty. However, several participants (n = 3) described ambiguities in the meaning of capacity to consent. For example, Lawyer 7 suggested that there is a blurred line between criteria for compulsory treatment and capacity:

Because, to obtain a compulsory treatment order, the person has to meet the threshold test. However, that doesn't mean the person is in a state of such unwellness [sic] that they're not capable of giving informed consent. (Lawyer 7)

Differentiation between consent and informed consent is tricky, as Lawyer 1 describes:

When you get consent, you've got to be really careful. This is a bit of an ethical judgment. Does this person, based on their current state of mind or predicament or illness, really have the mental capacity to give consent? It's a tricky little area so you've got to shift back to the core attributes of consent, you know of informed, not just consent, of informed consent. I believe you've still got a duty to inform the court that you are uncertain about certain aspects of their ability to give you informed consent. Now it's over to the court to really determine if that consent is valid. (Lawyer 1)

For Lawyer 6, “insight” and capacity were the same thing.

Sometimes you get a client who has really good insight and they'll say, "yes, I'll consent to this because I need to have the oversight, I've gone off the rails cause [sic] I've missed medication before, I need a nurse to keep an eye on me." And that can be really helpful. That's good insight. That's probably when I'll go to a full consent [while presenting evidence about clients' capacity to the court]. (Lawyer 6)

Lawyer 7 believed it was important to acknowledge the differences in legal and medical understandings and perceived credibility of capacity:

And the other thing that I'm conscious of is that I'm a lawyer, not a doctor. So when I check about my understanding about whether a person [has the capacity to] gives

informed consent, that's from a lawyer's point of view, not a doctor's point of view.
(Lawyer 7)

In summary, participants described the uncertainties they experienced in assessing clients' capacity to consent. Clients' behaviour, ability to instruct participants and understand legal advice were indicators of capacity. There are uncertainties about the legal determinations of capacity and its relationship with being "mentally disordered," informed consent, client insight and medical assessments of capacity to consent. These factors have ramifications for participants' perceptions of clients' credibility and therefore, their decisions to advocate upon their instructions.

6.1.3 Situation three: Personal safety versus obtaining clients' instructions confidentially.

Many (n = 7) participants described that they sometimes feel conflicted about whether they should meet with clients who may be dangerous, in a private setting, or exercise caution and compromise on obtaining their instructions confidentially or on obtaining them at all. Not all participants met with their clients privately, to protect their own safety, despite its ramifications for confidentiality and rigour of preparation for hearings. For instance, three participants illustrated the dilemma of weighing personal safety with lawyer-client privilege.

If the medical staff had said that whenever they are dealing with that person because of the danger issues there had to be a minimum of 2 or 3 people present, no one should ever be by themselves with that particular client. And they offer, would you like someone to sit with you during the meeting? And personally, I said no because I'm prepared to take the personal risk to insure the client doesn't have a nurse sitting there. So, I discussed it with other people in the team and we worked through what ethically we're obliged to do and we're not obliged to do that. So there are all sorts of ethical issues that we are faced with. (Lawyer 2)

One of my first patients was a lady in her 50s and the clinician then warned me that she was not beyond making approaches to males that were inappropriate and then later complaining about and misunderstanding what happened and just behaving inappropriately. So you've got to be careful that you don't put yourself in a position where not only your client is vulnerable but where you yourself as a counsel are vulnerable, and so that's part and parcel of mental health law. (Lawyer 9)

You do feel unsafe as a man and you'll get another nurse to sit in with you and sometimes that compromises the confidentiality that the client is entitled to. (Lawyer 6)

The participants often felt uncertain about the threat their clients would pose to their physical and emotional safety and professional integrity. In these situations, safety and professional reputation considerations were often prioritised over confidentiality and the development of a strong lawyer-client relationship.

Several participants (n = 3) explained that privacy and confidentiality concerns are particularly an issue for clients living in the community, therefore posing problems for the adequacy of preparations for hearings for them. Lawyers 10 and 4, for example, described how risks were greater in the community.

[Meeting clients in the community is] a little bit more difficult in the sense that I don't visit patients. I have done in the past visit patients at their home and I kind of feel that's not appropriate always. I have met with patients at the community clinics which is always good. I always contact the patients beforehand and if they're happy to meet with me beforehand at the hospital, that works as well but we basically canvas all the issues over the telephone. (Lawyer 10)

Lawyer 10 preferred to speak with clients over the phone or meet with them in community centres due to the risks of meeting clients at their homes. Lawyer 4 chose not to meet clients in their residential homes at all:

I refuse to visit patients in their own homes. Because I could be at risk and it's a real risk. I can be attacked and people have been so I don't do that. (Lawyer 4)

In summary, participants described that they are often required to make decisions about whether personal-safety concerns trump confidential lawyer-client relationships. They were uncertain about the effect of a particular client on their safety and, accordingly, many of them chose to err on the side of caution. They were particularly circumspect about meeting clients who lived in the community rather than in the hospital, due to greater uncertainties about the severity of risk. Participants suggested that this may pose challenges for the quality of their preparation and advocacy for hearings.

6.2 Theme Five: Barriers and Facilitators to Effective Legal Representation

Theme five explores the negative and positive aspects of the compulsory mental health system, available training for mental health lawyers, procedural factors and their ramifications for legal representation in the mental health law context. All participants (n = 11) explained how efficiencies and inefficiencies in the system or current practice restrict or facilitate preparation and advocacy before and during hearings. They also made recommendations for systematic and procedural reform to improve their quality of legal representation.

6.2.1 Systematic barriers and facilitators.

All participants (n = 11) identified systematic barriers and facilitators to effective legal representation. These include negative and positive aspects of access to resources, and the adequacy and quality of training available for mental health lawyers. Two subthemes resulted from the analysis, they are: hospital resources and training.

6.2.1.1 Hospital resources.

Four participants identified some issues with hospital resources that adversely impacted preparation for hearings. For instance, two participants experienced issues accessing independent spaces.

I think in the hospital facilities, there are generally interview rooms, not all the time. More interview rooms would be useful but I'll generally find a private room somewhere. (Lawyer 8)

If you saw [name of hospital] at the moment where they're demolishing it, there's a room this size [gestures]. There's around 15 people trying to use the room and talk and everything so it's very not independent, in my opinion. (Lawyer 3)

The participants recognised the need for private interview rooms to obtain clients' instructions confidentially. On the other hand, they also acknowledged positive aspects of hospital resources. Two participants explain,

The hospitals are good at arranging interpreters when they're necessary but they'll only do it as a standard process for a hearing. (Lawyer 8)

There's also an increasing number of Asian clients as well and there's no representation of them. Having said that, I do, and I think the others do too, you make use of other resources [within the hospital] like cultural facilitators, family coordinators, people like that. So, if I have a Māori client then I look for what support

they have, what support I can access, you know, that kind of thing.... So there are resources to call on within the hospital itself but sometimes it is outside agencies.

(Lawyer 7)

Overall, the participants mentioned that hospitals had good cultural and translation resources which allowed them to accommodate diverse cultural and language needs, and better represent clients who are minorities within the mental health system. They also explained that a lack of private rooms sometimes limited confidential and independent preparation for hearings which had negative ramifications for participants' preparation and advocacy potential under the MHA 1992.

6.2.1.2 Training.

Almost all (n = 10) participants identified the need to be trained in psychiatric diagnostic categories, mental health law, practical tools and cross-examination techniques. For example, three participants explained that psychiatric and psychopharmacological research was useful to their practice.

I think we all have to do background research - what the different mental disorders are, idiosyncrasies, how people present and what's actually wrong with them. (Lawyer 10)

I'm really interested in current therapeutic research and psychiatric research. There's a whole lot of global research going into best-practices methodologies, treatment of schizophrenia for instance. I'm really interested in psychopharmacology. A lot of new stuff is coming online for doctors that treats mental illness more effectively with less side-effects. (Lawyer 1)

Medication generally makes people feel very flat. All the medication is given for a reason. It's helpful to know what type of medication is supposed to be what. (Lawyer 2)

The participants described often conducting research into psychiatric diagnostic categories, associated behaviours, treatment and medications while representing clients in the mental health law context. This information aids participants to apprehend the magnitude of their clients' conditions, the impact of medications on their behaviour, and their treatment needs. Additionally, some of the participants recommended mental health legislation training and practical training on *how* to represent clients in mental health hearing and review processes. For example, Lawyer 1 identified the need for specialist training:

More specialisation would be a wonderful thing. I'd like to see a specialist bar and with possibly a specialist qualification even, like a certificate or diploma or even a postgraduate diploma in mental health law that would have both legal as well as clinical components. (Lawyer 1)

Lawyer 10 recommended a course for practising lawyers, as is offered in areas of law other than mental health.

Duty solicitors have to do a course and there's most other, I guess counsel for the child and the family court have to do a course. Maybe a short course? I'm just talking about a few hours just so that they understand the nuts and bolts of the Act and what's expected of them and there could be role playing, there could be video of a hearing, a dummy hearing just to see what the judges expect of counsel, that would be helpful for those entering into this sort of work. (Lawyer 10)

The participants suggested specialised formal training about the legislation, clinical components and procedural norms in mental health hearing and review processes. This was important to increase lawyers' mental health law and clinical knowledge, and confidence to practise in a specialised field. One participant suggested that training in advocacy, and cross-examination techniques suited to the mental health law context, would be beneficial. Lawyer 3 explains:

I think there needs to be a lot of training. I'm not confident at cross-examining ... but it's not enough to do the observations we do to then be a mental health lawyer and being expected to be able to do everything like cross-examining the clinicians. (Lawyer 3)

Training in interview and communication techniques suited to mentally unwell clients was also identified. Two participants felt it would improve their ability to interview clients and maximise disclosure of information.

It would be useful to do interviewing techniques for people with mental health unwellness [sic]. (Lawyer 3)

The only way would be for us to be trained [in communication with clients]. Are there ways that we can listen differently or take a different approach. (Lawyer 5)

In summary, participants recommended that additional specialist training in clinical and mental health law components would enable them to understand their clients' behaviour, diagnosis, and treatment, and better understand the health professionals' evidence and arguments which

justify their clients' compulsion. The participants recognised training in procedural expectations, cross-examination, communication and interview techniques as a significant factor to increase their confidence about representing clients with special needs and in a specialist field. Participants stated that training in these areas would enable them to play a more active role in clients' advocacy, by better understanding and meeting their needs.

6.2.2 Practical barriers and facilitators.

All participants (n = 11) referred to practical barriers and facilitators to effective legal representation during the interviews. Two subthemes resulted from the analysis. These are: difficulties communicating with mentally unwell clients, and evidentiary issues.

6.2.2.1 Communication difficulties.

The realities of working with mentally unwell clients who often cannot communicate articulately was elucidated by all participants (n = 11). Clients' mental illness may prevent participants from obtaining adequate instructions or providing effective advice. As described by Lawyer 4, communication issues may be greater for clients in hospital than those living in the community.

For example, if they're in hospital or if they're in a secure ward, which would mean they are really unwell and maybe totally irrational, like totally. (Lawyer 4)

Lawyer 8 explains the specific difficulties of working with people experiencing disorders which impact on their ability to communicate.

It's a challenge dealing with someone who has a disorder of cognition, someone who is so thought disordered that they don't make much sense so they can't really give you coherent instructions (Lawyer 8)

Lawyer 2 explained the effect of medication on clients' communication abilities:

I've had clients who I'm very sure haven't really taken on board anything I've said because of the level of medication they've received, because of how unwell they are. (Lawyer 2)

Several participants stated that it was difficult to reason with some clients:

If there's a fixed belief then you're not going to alter that belief. So you're not going to get through to them the way that you might want to. Like the person who says "I don't need to be here, I'm totally fine." It's fairly obvious that they're not fine at all and you will talk to them about, do you think that there's something wrong here or why you

came to be in here, how did you come to be in here...they'll tell you and you might try and steer them to see that something's wrong but if it's fixed people might not see it.
(Lawyer 5)

Clients' communication abilities had implications for their comprehension of legal advice. Difficulties obtaining coherent instructions impacted how strongly the participants could advocate for them. For example, Lawyer 7 and Lawyer 11 explained that it is difficult arguing for their clients' case without clear instructions from them,

Sometimes I might find one glimmer of hope [in clients' instructions]...one thing that I can hang cross-examination on [during hearings]. (Lawyer 7)

I try to be rigorous but if the client gives a good explanation about why then I will raise that in court and I will cross-examine on that basis. (Lawyer 11)

The participants found it challenging cross-examining evidence when their clients instructed them inadequately. Several participants identified that clients' presentations during hearings also undermine legal advocacy.

The words of their own mouth [during hearings] keep themselves in hospital. (Lawyer 6)

Many (n = 7) participants explained that they adopt creative techniques to overcome the challenges they experience in communicating with clients. For example, they adjust preparation techniques to meet clients' communication needs. Lawyer 3 demonstrated the efforts put into working with clients suffering specific disorders:

So there's all kinds of tools you can use. Things like little picture cards, computer technology and stuff that helps you work out and if it comes down to it – blink once for yes, blink twice for no. (Lawyer 3)

One participant described using open and closed-ended questions interchangeably.

I'll ask some pretty general questions along those lines, but I'll keep them closed. So, really closed questions, really direct. I'll let the client talk more freely but on the legal points I ask closed questions because I'm trying to define where the angle is. (Lawyer 6)

During legal processes Lawyer 10 made an effort to meet clients' levels of understanding regarding legal processes under the MHA 1992.

But at the hearings we use simple language, I don't think that we make things too difficult for people to understand because you sort of gauge at it according to their level of intellect, and having read all the papers, you do learn, and the notes, you do know about their backgrounds and whether they have had higher education. (Lawyer 10)

Two participants mentioned that they spent extra time with clients to comprehend their instructions beyond its face value.

What I find is even clients who are in a state of unwellness, you just have to spend a bit more time and what you've actually got to do is you don't disrupt the narrative, you let them explain and you've really got to have your antennae up. (Lawyer 11)

As long as it takes. Sometimes interviews are painfully long. Because patients, they're just And you've got, you know, you have to, you've got a duty to discharge so in many cases you just let these rambling narratives run. They go all over the place and your job is to tie it back in. You've got to draw the threads through as best as you can. Sometimes you can't. Sometimes it's just too disperse. Too fragmented. (Lawyer 1)

All participants described communication difficulties as a major barrier to providing accessible legal advice, obtaining articulate instructions and advocating for clients in legal processes. The participants emphasised that communication issues were a reality of practising in mental health law, therefore their ability to advocate for their clients depended on how well they could communicate with them. However, several participants made additional efforts to maximise preparation to ensure that advocacy stayed on their clients' instructions, by adopting innovative tools and techniques to enhance communication.

6.2.2.2 Evidence.

All participants (n = 11) mentioned that evidentiary issues sometimes restricted their ability to advocate for clients. One such issue discussed by participants was that it was difficult to argue against "mental disorder," particularly the first limb, without a second opinion from a psychiatrist. Three participants illustrated this:

Mental disorders are hard to argue against unless you have another medical opinion. (Lawyer 6)

And the first limb, you may as well want to get some specialist, expert evidence yourself in terms of that because if you're presenting the case, you need to present evidence that

what your client says is the case and that they're aware. I'm not a psychiatrist. (Lawyer 2)

I had said "look, the only way you can really get out of this is getting a second opinion who would say what you wanted." (Lawyer 3)

The participants believed that the first limb of mental disorder, is a specialist category and they had limited expertise to challenge it without the opinion of another psychiatrist. They found it difficult to challenge mental disorder and explained that these criteria were influenced strongly by psychiatrists.

Despite medical dominance, several participants stated that there were times when they had proved that the hospital's evidence was unsatisfactory, unconvincing and inaccurately applied to the mental disorder criteria which resulted in them successfully facilitating their clients' release from compulsory treatment. Three participants describe this.

That's simply because in some cases where a client is successful, it's because the hospital's evidence is quite borderline and they do need to do some homework about things and maybe the patient doesn't need to be in there. (Lawyer 7)

And I've had successes against them [doctors] because I've really challenged them and convinced the judge that well, the doctor just hasn't done the sufficient work to satisfy the judge for example, that they're mentally unwell. (Lawyer 4)

It [hospital evidence] was kind of sitting on the fence, it could go either way. And I think at the end of the day it was probably the doctor on the tribunal who probably agreed with me. (Lawyer 10)

The participants show that they had successful legal outcomes because the hospital evidence was inaccurate and they were able to convince the judges and tribunal panels of this fact.

The acceptance of hearsay or family evidence by courts and tribunals in their decision-making was perceived by some participants as undermining the arguments they made for their clients' cases. For instance, Lawyer 8 critiqued the weight given to this kind of evidence by courts and tribunals, despite uncertainties about its trustworthiness.

There's a provision in the Act of course that evidence can be admitted in hearsay form, we're not bound by the rules of evidence so that means the doctors can give hearsay evidence, which they do on behalf of family members but that's where you have to know what's going on in the background – how reliable are the family members? (Lawyer 8)

Two participants demonstrated the significance of hearsay evidence in decision-making. They described how family evidence contrary to their clients' objectives was of importance to the judge.

We're there to try and convince the judge that they [client] shouldn't be in there. But as often as not the parent is in there and has a very difficult job because they personally believe that the person should be under the Mental Health Act but are very circumspect about what they say and how they say it in the hearing. Sometimes parents will come in and be invited by the judge to say something but preferred not to say to them with the fear of upsetting the child. And that really is telling the judge that they really agree with the doctor but they don't want to say it. One of the interesting dynamics.
(Lawyer 4)

Family members interrupting and saying they should be here. Often the judge will ask the family and the family is obviously genuinely concerned about their children. And they want to abide by the medical opinion or agree that he should be in there. (Lawyer 5)

The participants, therefore, described how the decision-makers' acceptance of family and hearsay evidence that opposes clients' cases negatively impacts lawyers' advocacy and the case for their client. Conversely, some of the participants highlighted how family evidence could strengthen their advocacy. Lawyer 2 illustrated that family evidence that coincided with clients' instructions supported their case:

Like with any client that's going to court, evidence is key. And hopefully you can work with a client and if there's support people, family members who can support you with that, that's all good stuff to bring. And it's really just again presenting the case to the judge and saying, look there are compelling reasons why this person does not need to be subject to compulsory treatment. (Lawyer 2)

In summary, participants explained how evidentiary issues restricted provisions of effective legal representation. Medical evidence, despite being of a hearsay and third-hand nature, was dominant in court and tribunal decision-making. One reason for its dominance was the participants' feeling that they are unqualified to challenge the first limb of mental disorder without obtaining another psychiatrist's opinion. However, there were times when they successfully facilitated their clients' release from the MHA 1992 due to the unsatisfactory quality of health professionals' evidence. The participants described that the significance of

health professionals' or families' evidence that may have credibility issues in court and tribunal decision-making, and limited ability to review or challenge medical evidence sometimes has adverse effects on their ability to advocate for their clients.

6.3 Summary

This chapter presented two themes on the barriers and facilitators to providing effective legal representation. The first section of this chapter described the fourth theme of the analysis, the dilemmas and ethical challenges participants experienced in regard to adopting a best-interest approach to advocacy or acting on clients' instructions while preparing and advocating for legal processes. Three situations in which participants were required to make tricky ethical decisions were: i) balancing civil liberties with treatment needs, ii) assessing clients' capacity or lack of capacity to consent to CompTO hearings, and iii) deciding whether to interview and obtain clients' instructions in private or public spaces or obtain them at all when there are personal-safety concerns. There were times when the participants chose to act in their clients' best interests due to their personal and professional reputations and to maintain clients' wellbeing, treatment and public safety. Due to the challenges associated with representing clients who may be unwell or irrational, and lack competency, participants felt that it may be more practical and ethical to act in clients' best interests.

The second section described theme five, the systematic and practical barriers and facilitators participants experienced when preparing for hearings and advocating on clients' instructions. The systematic factors included hospital resources and the quality of training to practise in the mental health law context; while the practical factors included communication difficulties and evidentiary challenges and enablers. Some of the participants occasionally felt unequipped to advocate strongly on clients' instructions due to limited opportunities to interact with clients privately, lack of mental health training, difficulties communicating with their clients, the dominance of medical evidence and unquestioning acceptance of hearsay evidence in legal decision-making in the mental health law context. These factors can negatively impact the quality of legal representation and advocacy, and on clients having their needs and objectives met. However, some participants adopt creative techniques to overcome the challenges they experience communicating with their clients, in order to best meet their needs and desires.

The next chapter will discuss the findings presented in Chapters 5 and 6 in relation to international and New Zealand literature on legal representation in the mental health law

context. It emphasises the main findings of this thesis and makes suggestions for future research, policy and practice.

CHAPTER SEVEN: DISCUSSION

This thesis explored the experiences and perspectives of a small sample of lawyers who represent clients under the MHA 1992. It focused on their practices while they prepare and advocate for clients across the section 16 review, the section 18 review and/or the defended CompTO hearing and the MHRT hearing. Specific attention was also paid to the barriers and facilitators to effective legal representation and how lawyers overcome the challenges they frequently encounter. The study adopted a qualitative descriptive methodology. Data was collected through semi-structured interviews with 11 Auckland and Waikato mental health lawyers and analysed using thematic analysis. Empirical methodology provided additional insights into participants' interactions with health professionals, clients and other relevant parties and the impact of legal representation on the individuals - mental health patients - who are predominantly affected by this practice.

Overall, the findings presented in this thesis demonstrate that the mental health lawyer has a broader role than protecting patients' legal rights alone. This role encompasses legal, health and social functions, all of which were considered by participants in this study as equally important to effective legal representation. However, participants experience several challenges in the mental health law context which, at times, prevent this role from achieving its positive potential. To show how the study attained this core finding, the first section of this chapter synthesises the findings under four themes within the context of existing knowledge in this area, and discusses their theoretical, policy and legal implications. These four themes are i) attending to extra-legal issues, ii) the relationship between health professionals and lawyers, iii) facilitating client participation in legal processes, and iv) ensuring the accuracy of evidence. The second section of this chapter outlines the strengths and limitations of this study. The third section of this chapter highlights the study's implications for practice, policy and research. The chapter concludes by summarising this thesis.

7.1 Addressing the Themes

7.1.1 Theme 1: Attending to extra-legal issues.

This study found that the participants promote their clients' health and recovery concerns even though this function can be considered extra-legal or external to their traditional legal role. Although their practices which attend to extra-legal factors can improve clients' quality of life

during their compulsory treatment, the findings also indicated that participants' ability to advocate for and successfully meet their clients' health-care needs can be limited.

Participants supported their clients' long-term therapeutic goals by empowering them to gain insight into their mental condition by assisting them in self-management of their health and wellbeing. Some participants claimed that the reiteration of legal rights, processes and the consequences of a CompTO might help their clients to consolidate the importance of treatment for their mental condition, wellbeing and eventual release from compulsory treatment, as per their wishes. None of the literature discusses how lawyers can promote insight, however, PJ theory argues that individuals who are respected by an authoritative figure may be more likely to comply with treatment (Tyler, 1992; Winick, 1999). This finding shows lawyers' perspectives on the positive impact of PJ on therapeutic goals.

The participants also supported long-term therapeutic goals by promoting their clients' grievances and wishes to the clinical teams to improve the quality of their compulsory treatment conditions. They advocated for changes in their clients' treatment including dose and type of medication, access to leave and less restrictive treatment options, for example, community rather than inpatient treatment. They also raised awareness among the clinical teams about their clients' wellbeing needs by facilitating a discussion between client, treatment team and judge or tribunal panel. These actions align with principles of the United Nations Convention on the Rights of Persons with Disabilities (2006) which asserts that persons should be supported to exercise their legal capacity (article 12, 3), have the right to promote their "will and preferences" (article 12, 4) in "all legal processes, including investigative and preliminary stages" (article 13, 1). Additionally, several theorists argue that lawyers' incorporation of their clients' "subjective" views during advocacy can facilitate improvements in the quality of their treatment and social conditions (Dawson, 1986; Pearson, 2004; Weller, 2011). This study confirms that these arguments translate into practice and shows how lawyers can facilitate broader social and health outcomes for their clients.

The participants indicated, however, that their ability to advocate for changes in their clients' compulsory treatment conditions was sometimes limited due to the narrow jurisdictional parameters of the mental health hearing and review processes. Although they raised their clients' extra-legal issues, their role was limited to advising the clinical teams. On other occasions, they achieved changes indirectly by relaying their client's wishes to the judge who then directed the clinical team to improve the patient's treatment or leave plans. This finding

is evident in New Zealand and international literature, which also discuss the benefits of extending the limited powers of MHTs/MHRTs to manage the health and social aspects of patients' lives to meet their needs best (Beaupert, 2009; Carney, Beaupert, et al., 2008; Carney & Tait, 2011; Carney, Tait, & Beaupert, 2008; Dawson, 1986; Diesfeld & McKenna, 2006; Thom et al., 2015).

In summary, this section has shown that the mental health lawyer can strengthen the relationship between law and psychiatry by using advocacy and due process to promote long-term therapeutic outcomes for mental health patients, in alignment with their wishes and needs. Although participants sometimes successfully improved their clients' compulsory treatment conditions and raised awareness about their needs to the clinical teams, they described having limited ability to achieve their clients' objectives related to the condition of their detention. This highlights a need for better access to health and social advocacy for patients, for example, greater dispersion of power to lawyers to enhance their ability to meet their clients' extra-legal needs.

7.1.2 Theme 2: The relationship between health professionals and lawyers.

The findings of this study suggested that participants and health professionals have a collaborative relationship even though they have different objectives for the protection of patients' liberty and treatment rights respectively. Although participants described some benefits to the various interactions that take place between both parties, collaboration sometimes results in participants acting on clinical opinion and not on their clients' instructions.

This study revealed several positive impacts of good relationships between health professionals and the participants on the quality of their legal representation. Information about RCs' justification for compulsory treatment allows some participants to develop stronger legal arguments and negotiate adjournments for greater preparation time to support their clients' case. No research-based literature described the positive potential of this collaboration on the enhancement of legal rigour.

Another positive consequence of participants' contact with health professionals' evidence in this study was an enhanced ability to provide non-distressing yet rigorous advocacy. This enables them to gauge their clients' psychological state and reschedule interviews to meet their emotional and psychological needs. Additionally, they persuade clinicians to adjourn CompTO

hearings if there is evidence that their clients are recovering, to prevent them from experiencing an unsuccessful hearing, while facilitating their successful release from compulsory treatment at a future date. These actions align with a growing body of work on alternative models of legal representation that highlights its relational potential to minimise the anti-therapeutic consequences of legal processes without subordinating due process (Daicoff, 2006; Weller, 2011; Winick, 1999).

The study found that participants' collection of evidence from health professionals sometimes affected their practice in negative ways. Information about clients' incapacity sometimes disrupts their ability and desire to rely on the explicit instructions of clients. Evidence about their clients' dangerousness may put participants in a quandary about whether to obtain clients' instructions confidentially, or obtain them at all. These findings support the literature which has claimed that awareness of clients' illness and dangerousness may result in lawyers acting in clients' best interest and not directly on their instructions (Carney & Tait, 2011; Du Fresne, 2003; Luchins et al., 2006). However, the participants in this study exemplified awareness of these adverse impacts which led to them making the calculated decision not to discuss their clients' situations with health professionals, in order to better advocate upon their clients' instructions.

The dilemmas resulting from the relationship between participants and health professionals continued to feature in the findings of this study, in relation to challenging psychiatric testimony. In some situations, participants chose not to challenge clinical opinion because they did not want to belittle psychiatrists and present false arguments that they could not rely on. Perlin and Lynch (2016) discuss sanism, arguing that lawyers may feel uneasy about promoting irrational instructions that oppose trained medical experts' views. Rather than evidence of sanism, this study found that lawyers' support of clinical opinion over their clients' instructions may, at times, have been because of the clinicians' expertise and recognition of the severity of their clients' illness from them. This shows that it was the participants' belief that it was not always ethical to act on their clients' instructions that contributed to participants' reluctance to challenge clinical opinion, rather than discriminatory attitudes.

In summary, this section has shown that the mental health context influences the role of the mental health lawyer. The "Mental Health Practice Standards" (Ministry of Justice, 2011b; pp. 25-56) and the Mental Health Roster guidelines (ADLS, 2010) imply the importance of lawyers' relationship with health professionals in producing rigorous and ethical practice.

However, because health professionals have more psychiatric expertise and greater contact with their clients, the participants sometimes depended on their opinion to understand the severity of their clients' illness, which at times resulted in them acting in their clients' medical interests rather than promoting their liberty rights.

7.1.3 Theme 3: Facilitating client participation in legal processes.

The findings of this study demonstrated that the participants attempted to empower their clients to exercise their legal capacity to produce fair hearings for them. However, it was not always possible to facilitate their participation due to the communication difficulties associated with the severity of their illness.

The participants specified the personality characteristics and techniques that helped them build their clients' legal capacity that was necessary for fair hearings. They exhibit numerous characteristics, including sensitivity, empathy and active listening to develop rapport and trust, to maximise their clients' disclosure of information, which is significant for effective advocacy. Creative techniques, including blinking, open-ended/closed-ending questioning, charts and information sheets, also aid participants to obtain useful instructions from clients and overcome communication difficulties. Additionally, they advise their clients about review rights and legal processes to ensure that they have realistic expectations about hearing outcomes and are empowered to make choices about withdrawing or pursuing review applications. This finding supports theoretical literature on alternative approaches to legal representation which claims that lawyers should meet their clients' psychological needs (Daicoff, 2015, 2016). Additionally, it adds to the growing literature on "supported decision-making" in the mental health law context which posits that lawyers should support individuals who have limited legal capacity to make decisions rather than "substitute" personal views for them (Dinerstein, 2012; Fritze, 2015; Perlin & Weinstein, 2016). This study contributes to the research-based literature and New Zealand policy (ADLS, 2010) by exemplifying practical strategies that could help lawyers to build their clients' legal capacity in spite of their illness.

The study exemplified how participation in legal processes increased clients' perceptions of "fairness". In alignment with PJ theory (Tyler, 1992), the participants explained that their clients usually feel satisfied with legal processes, even though they are not released from compulsory treatment, because they have had the opportunity to be heard. However, one participant gave an example of a client who was dissatisfied with the legal processes, despite being heard, this suggesting that the impact of due process could be individualised. This finding

contributes qualitative insights, from practising lawyers' viewpoints, into the impact of PJ in practice.

This study found that for some participants, systematic barriers negatively affects their ability to build their clients' capacity, therefore averting "fair" hearings for them. Limited access to hospital rooms prevents them from interviewing their clients confidentially and developing good relationships with them. Despite brief guidelines which outline how participants should contact community patients (ADLS, 2010), they feel conflicted about whether it is safe to visit them at their residence, sometimes preventing them obtaining their instructions at all. Carney (2012) discussed the need for "adequate physical spaces," including hearing rooms, to raise the participation of non-medical individuals in legal processes, to equal that of health professionals. Similar findings were absent in the literature, indicating an important resource that could assist lawyers practising in this area, internationally.

The findings of this study suggested that in some situations participants experienced advocacy dilemmas due to uncertainties about the meaning of "capacity to give informed consent," thus preventing fair hearings. While some theorists acknowledge that lawyers might experience difficulties establishing their clients' competence and the believability of their instructions (Morris, 2009; Perlin & Lynch, 2016), none of the literature specifies the nature of this dilemma. In this study, the participants indicated feeling unsure about the association between their clients' behaviour, condition, medical determinations of capacity and insight, and capacity or incapacity to consent to CompTO hearings, which can result in them not always believing and acting on their clients' instructions.

The results of this study showed that communication difficulties sometimes adversely affect participants' ability to facilitate fair hearings. Being unable to obtain rational instructions from their clients, due to their illness, negatively affected their ability to develop strong arguments to support their cases in front of courts and tribunals, as evident in the literature (Beupert, 2009; Carney, Beupert, et al., 2008; Carney & Tait, 2011). Additionally, communication which indicated illness put some participants in an ethical fix about whether their role was to act on their clients' instructions or in their best interest, which sometimes resulted in them not promoting clients' instructions, contrary to best-practice guidelines (ADLS, 2010; Ministry of Justice, 2011b). In contrast to the theoretical literature, which argues that role ambiguity is due to the inquisitorial nature of legal processes (Diesfeld & McKenna, 2007; Freckelton, 2003;

Pearson, 2004; Perlin & Lynch, 2016; Rogers, 1994; Weller, 2011), this study suggests, instead, that it may be because lawyers feel concerned about their clients' health.

In summary, the findings in this section have demonstrated that participants play a critical role in empowering their clients to participate in legal processes. It builds on several theorists' contentions that legal representation can increase the fairness of hearings by showing *how* lawyers can facilitate fair legal processes by building clients' legal capacity and enabling them to make choices about their compulsory treatment (Carney, 2011; Du Fresne, 1996). Although the participants adopt techniques to overcome communication difficulties with clients, at times, their ability to produce fair hearings may be constrained by their clients' illness, which result in them not being able to obtain enough information to support their cases vigorously.

7.1.4 Theme 4: Ensuring the accuracy of evidence.

This study found that participants check the accuracy of health professionals' evidence that justifies their clients' compulsion to ensure the legality of detention by cross-examining health professionals' evidence. However, participants' ability to ensure accurate decision-making may be constrained by inadequate psychiatric knowledge, difficulties cross-examining clinicians and the dominance of medical evidence over their clients' evidence in court and tribunal processes.

The participants gave detailed descriptions of the purpose and content of cross-examination, illuminating its importance for the accuracy of legal decision-making. They incorporate a client's agreement/disagreement with the RC's opinion of mental disorder as they cross-examine clinicians, allowing them to assert the strengths of their client's case, provide alternative explanations for their behaviour, highlight inaccuracies and exaggerations in the evidence and to ensure that the legal decision-makers have access to all relevant information. For example, one participant cross-examined the clinician's opinion that the patient should continue to be compulsorily treated because his release would disrupt his family relationships. By cross-examining, lawyers can show decision-makers that the hospital's evidence has been inaccurately applied to the statutory criteria for compulsory treatment. For some participants, their cross-examination resulted in the successful release of clients who were being erroneously detained by their clinicians for paternalistic or lifestyle reasons. This study supports theoretical literature that has claimed that the role of the lawyer is to highlight exaggerations and inaccuracies in psychiatrists' opinions and prevent unlawful detention (Du Fresne, 1996; Freckelton, 2003; Rogers, 1994; Sarkar & Adshead, 2005). However, none of the research-

based and scarce theoretical literature details effective cross-examination and its impact in the mental health law context, therefore the study provides a useful tool for practising lawyers.

The participants described how they cross-examine sensitively and tactfully to promote therapeutic goals and relationships, while simultaneously promoting accurate decision-making. Non-confrontational cross-examination preserves existing relationships with family and health professionals. For example, a participant requested his client leave the hearing room while he cross-examined his clinician and family. The cross-examination techniques adopted by the participants of this study align with TJ which argues that lawyers should act therapeutically, including cross-examining sensitively and non-confrontationally, without subordinating due-process principles (Freckelton, 2003; Winick, 1999; 2003). This study adds to the body of research-based literature on this topic and also shows how some of these participants' practices reflect the principles of alternative approaches to legal representation.

Limited psychiatric knowledge, however, may hinder the participants in cross-examining the first limb of mental disorder, therefore compromising the accuracy of decision-making. Although there were times when the participants challenged clinical opinion, on other occasions the participants were dependent on their clients' agreement/disagreement with the clinician's opinion to challenge mental disorder. Furthermore, several participants stated being unable to challenge the first limb of mental disorder without obtaining a second opinion from a psychiatrist. This supports some of the literature which contends that lawyers might rely on psychiatrists to inform the medical aspects of the criteria for compulsion due to limited psychiatric expertise (Diesfeld, 2003, 2013; Diesfeld & Sjöström, 2007; Perkins, 2003).

In alignment with several research-based studies (Campbell, 2008; Carney & Beaupert, 2008; Carney, Beaupert, et al., 2008; Perkins, 2003), the participants of this study described that medical evidence dominates in court, and tribunal decision-making, over non-medical evidence. This is despite the fact that medical evidence could be characterised as being of a hearsay and third-hand nature. However, the findings of this study demonstrated how participants, on some occasions, successfully secured their clients' release from compulsory treatment by highlighting inaccuracies in the health professionals' evidence and application of mental disorder. As evident in the non-empirical literature (Sarkar & Adshead, 2005), this study also shows that lawyers can play an important role in lowering medical dominance in these processes and facilitate successful outcomes contrary to the clinician's opinion (Pearson, 2004; Rogers, 1994).

In summary, this section has shown that participants play a critical role in ensuring that legal-decision-makers consider accurate evidence and enhancing the liberty rights protections aims of the MHA 1992. Although lawyers cross-examine health professionals' evidence tactfully and rigorously, limited psychiatric experience, and courts' and tribunals' preferences for medical evidence over their clients' information despite it being of a hearsay nature, might restrict participants' ability to ensure accurate decision-making.

7.2 Strength and Limitations

This section outlines the strengths and limitations of this thesis.

This study contributes research-based evidence to existing medico-legal literature on how the lawyer's role works in practice. Most of the previous research on this topic was theoretical and explored by "insiders" to this field. Additionally, the limited existing empirical evidence on the lawyer's role is a bi-product of studies which researched the impact of MHT/ MHRTs in practice. The study examined lawyers' practices in the mental health law context thoroughly. Although it focused on the New Zealand context, given the similarities in the purpose of the role of the mental health lawyer, it is likely that some of these findings will be transferable to overseas jurisdictions.

The qualitative descriptive research design enabled collection of rich data and detailed responses about the topic within the time constraints of a master's-level thesis. It captured variations in lawyers' practices and gave them the opportunity to explain their actions. This research highlighted legal practitioners' perspectives on the boundaries of their roles' impact on their clients and on decision-makers.

The researcher had no prior research or practical experience in mental health law, which allowed a fresh perspective on the research process. It enabled the identification and collation of important aspects of legal representation from the lawyers' views rather than the researcher's beliefs founded on previous knowledge in this area.

The sample of this study was limited and could be addressed by future research with lawyers in other regions of New Zealand. The sample consists of approximately 20% of Auckland and 60% of Waikato mental health lawyers which does not necessarily reflect the practices of mental health lawyers in other areas of New Zealand. This study's participants expressed that there were regional variances in lawyering practices and access to legal representation. A larger study may provide a more holistic understanding of how mental health lawyering works in the

New Zealand context. Nevertheless, this study captured the core functions of mental health lawyers which were sufficient to fulfil this study's aims.

This research was constrained to using one method, given the time constraints of a master's-level thesis. Triangulation or the use of multiple data collection methods, also including hearing observations and interviews with other stakeholders (Crowther-Dowey & Fussey, 2013a), could have strengthened the reliability of this study. As the individuals most affected by legal representation, patients' perspectives are vital to evaluating its quality and enhancing rights protection and promotion. The current method of semi-structured interviews nevertheless resulted in the collection of sufficient amounts of data to answer the research question well.

Although being an outsider to the field was a strength of this study, the researcher's identification at the beginning of the interviews, as a student with a non-law background, may have impacted the complexity of the information shared by the participants.

7.3 Implications of this Study

7.3.1 Implications for policy and practice.

This study was the first of its kind in New Zealand to focus on the lawyer's role and their experiences and perspectives of representing mental health patients. This section, therefore, discusses the implications of this study's findings for policy and practice in the New Zealand mental health law context.

The findings suggest that specialist training in several areas would benefit practising lawyers. Training in interviewing and communication techniques would enhance their ability to interview and obtain the instructions of unwell clients effectively. Training in psychiatric categories, including medication and side-effects, would enhance lawyers' ability to understand their clients' behaviour independent of health professionals, and promote their needs and rights to clinicians and legal decision-makers. Training in cross-examination techniques would increase lawyers' confidence about cross-examining clinicians and increase the rigour of mental health lawyering. Lastly, role training would raise awareness among legal practitioners of the potential positive effects of legal representation, including accuracy, fairness, empowerment and therapeutic goals, and encourage them to reflect on their practice. Furthermore, role-training might encourage them to provide more effective legal representation in the future.

It is important to address structural issues faced by lawyers including the limited availability of hospital interview rooms and difficulties accessing community patients. Improved access to these resources may facilitate consistent preparation for hearings by enabling lawyers to interview all their clients confidentially and effectively.

The broadening of the jurisdiction of mental health laws might allow lawyers to contribute to changes in their clients' extra-legal concerns as per their instructions. Alternatively, improved access to health and social advocacy services would meet patients' health and social needs best, without the input of their lawyers.

It is important that courts and tribunals accept medical and non-medical evidence equally in their decision-making. It will maximise lawyers' ability to protect their clients' liberty rights and enable processes to be fairer for them.

7.3.2 Future research.

This study points to future research to further understand how to improve the quality of legal representation and optimise its positive impact on mental health patients.

Future research warrants an exploration of mental health patients' experiences and perspectives of legal representation. As the individuals predominantly affected by legal representation, their experiences and perceptions about this topic are important to improve its quality, provision and maximise its positive impact on patients.

An incidental finding of this study was that participants sometimes found it difficult to determine clients' capacity to consent to CompTO hearings which decreased the believability of their clients' instructions and increased their reliance on health professionals to inform this evidence. It highlights a need for greater understanding of the meaning of capacity and may reveal whether capacity criteria would improve the quality of legal representation.

Future research should explore the impact of court and tribunal decision-making on legal representation. It would explain the impact of evidentiary norms on the quality of legal representation and would specifically reveal how lawyers' ability to advocate for patients' rights may be improved.

7.4 Conclusion

This study was the first of its kind in New Zealand and internationally to thoroughly explore the experiences and perspectives of a small sample (n = 11) of mental health lawyers as they advocate for clients in the section 16 review, the section 18 review and/or the defended CompTO hearing and the MHRT hearing. It gained additional insights into participants' interactions with health professionals and clients, and the barriers and facilitators that they experienced to achieving successful therapeutic, fairness and accuracy outcomes for their clients. This research contributes to the literature on the topic by providing insights into how this role translates in practice. Additionally, it specifies how lawyers *should* practise, from practising lawyers' viewpoints, which is largely missing from the literature and New Zealand policy in this area (ADLS, 2010; Ministry of Justice, 2011b)

The core finding of this thesis is that the participants have a broad function under the MHA 1992. They have the potential to produce not only legal but also some health and social outcomes for their clients, all of which the participants stated were equally important to effective legal representation and optimal patient outcomes in the mental health law context. In most situations, because participants are unlikely to secure their clients' release from compulsory treatment due to their illness, they support them in self-determination about their health and wellbeing and relay their choices to clinical and legal decision-makers. Clients' input into the health care and treatment that they receive may enable them to experience fairer hearings and advance their therapeutic goals. The participants also play a significant role in protecting their clients' civil liberties by ensuring the accuracy of health professionals' evidence put forward to justify their compulsory treatment. However, the study's findings demonstrated that the participants may face several barriers to promoting therapeutic, fair and accurate outcomes for their clients while practising in the mental health law context. These barriers include a limited power to advocate for clients' social and health concerns and effect changes in their treatment and leave plans; dependence on health professionals' interpretation of clients' mental health; communication challenges with clients; limited psychiatric training and knowledge to assess, review and cross-examine the health professionals; and decision-makers' preference for medical evidence over their clients' information in legal processes.

The barriers to effective legal representation may perpetuate "best-interest" rather than "empowering" approaches to lawyering that prioritise clinical opinion over their clients' circumstances and choices. This thesis provides a platform for further investigation into

maximising mental health lawyers' ability to enhance the protection and promotion of patients' liberty, psychological and treatment needs, and rights.

Appendix A: University of Auckland Ethics Approval



Office of the Vice-Chancellor

Finance, Ethics and Compliance

UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE (UAHPEC)

18-Apr-2016

MEMORANDUM TO:

Dr Catherine Prebble, Nursing

Re: Application for Ethics Approval (Our Ref. 017308): Approved with comment

The Committee considered your application for ethics approval for your project entitled **Lawyers' perspectives on barriers and facilitators to providing effective legal representation to service users under the Mental Health (Compulsory Assessment and Treatment Act) 1992.**

Ethics approval was given for a period of three years with the following comment(s):

Is it possible there might be some incidental findings that could arise from a discussion that might have had an impact on both client and lawyer and how have the researchers considered this?

The expiry date for this approval is 18-Apr-2019.

If the project changes significantly you are required to resubmit a new application to UAHPEC for further consideration.

In order that an up-to-date record can be maintained, you are requested to notify UAHPEC once your project is completed.

The Chair and the members of UAHPEC would be happy to discuss general matters relating to ethics approvals if you wish to do so. Contact should be made through the UAHPEC Ethics Administrators at ro-ethics@auckland.ac.nz in the first instance.

All communication with the UAHPEC regarding this application should include this reference number: **017308.**

(This is a computer-generated letter. No signature required.)

Secretary University of Auckland Human Participants Ethics Committee

c.c. Head of Department / School, Nursing
Dr Lisa Williams
Miss Anshita Thakkar

Appendix B: University of Auckland Ethics Amendment Approval 2



Office of the Vice-Chancellor

Finance, Ethics and Compliance

UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE (UAHPEC)

19-May-2016

MEMORANDUM TO:

Dr Catherine Prebble
Nursing

Re: Request for change of Ethics Approval Ethics Approval (Our Ref. 017308): Amendments Approved

The Committee considered your request for change for your project entitled **Lawyers' perspectives on barriers and facilitators to providing effective legal representation to service users under the Mental Health (Compulsory Assessment and Treatment Act) 1992** and approval was granted for the following amendments on 19-Jun-2016.

The Committee approved the following amendments:

1. To remove co-investigator Professor Kate Diesfeld from the research personnel team.
2. To add co-investigator Dr Katey Thom to the research personnel team
3. To remove the investigation of patient outcomes as a study aim.
4. To extend the participant withdrawal by one month to allow for time for participants to review their transcripts
5. To include a statement that if participants withdraw their recordings and transcript will be immediately destroyed.
6. The addition of two lines in the first paragraph of the PIS explaining that the study sits within a platform of research and will probably lead to further study on this topic. This is to address the concerns of the Mental Health & Disability Committee of the Auckland District Law Society Inc (ADLSI).
7. To add the words 'Auckland and South Auckland roster' to the email invitation. This is at the request of the ADLSI.
8. To the addition of a statement to both PIS and both consent forms explaining that the ADLSI Mental Health & Disability Committee will not be informed about the identity of lawyers who participate.
9. To amendments to the Interview Schedule

The expiry date for this approval is 18-Apr-2019.

If the project changes significantly you are required to resubmit a new application to the Committee for further consideration.

In order that an up-to-date record can be maintained, it would be appreciated if you could notify the Committee once your project is completed.

The Chair and the members of the Committee would be happy to discuss general matters relating to ethics approvals. If you wish to do so, please contact the UAHPEC Ethics Administrators at ro-ethics@auckland.ac.nz in the first instance.

Please quote reference number: **017308** on all communication with the UAHPEC regarding this application.

(This is a computer-generated letter. No signature required.)

UAHPEC Administrators University of Auckland Human Participants Ethics Committee

c.c. Head of Department / School, Nursing
Dr Catherine Prebble
Dr Lisa Williams
Miss Anshita Thakkar

Appendix C: University of Auckland Ethics Amendment Approval 3



Office of the Vice-Chancellor

Finance, Ethics and Compliance

UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE (UAHPEC)

26-Jul-2016

MEMORANDUM TO:

Dr Catherine Prebble Nursing

Re: Request for change of Ethics Approval Ethics Approval (Our Ref. 017308): Amendments Approved

The Committee considered your request for change for your project entitled **Lawyers' perspectives on barriers and facilitators to providing effective legal representation to service users under the Mental Health (Compulsory Assessment and Treatment Act) 1992** and approval was granted for the following amendments on 26-Jul-2016.

The Committee approved the following amendments:

1. To extend recruitment for potential participants beyond Auckland to other New Zealand regions or cities.
2. To change the recruitment protocol to allow the research team to contact potential participants (lawyers) directly via email and a follow up phone call.
3. To include telephone or skype interviews if necessary, or if preferred by potential participants.

The expiry date for this approval is 18-Apr-2019.

If the project changes significantly you are required to resubmit a new application to the Committee for further consideration.

In order that an up-to-date record can be maintained, it would be appreciated if you could notify the Committee once your project is completed.

The Chair and the members of the Committee would be happy to discuss general matters relating to ethics approvals. If you wish to do so, please contact the UAHPEC Ethics Administrators at ro-ethics@auckland.ac.nz in the first instance.

Please quote reference number: **017308** on all communication with the UAHPEC regarding this application.

(This is a computer-generated letter. No signature required.)

UAHPEC Administrators University of Auckland Human Participants Ethics Committee

c.c. Head of Department / School, Nursing

Dr Catherine Prebble

Dr Lisa Williams

Miss Anshita Thakkar

Appendix D: Participant Invitation



Faculty of Medical and Health Sciences
85 Park Road, Grafton, Auckland 2760
Telephone 64 9 373 7599
Facsimile 64 9 367 7158

The University of Auckland
Private Bag 92019, Auckland 1142
New Zealand

EMAIL INVITATION

Project Title: Lawyers' perspectives on barriers and facilitators to providing effective legal representation to service users under the Mental Health (Compulsory Assessment and Treatment) Act (MHA) 1992

EMAIL

Subject line: Research on lawyers representing mental health patients

Email content:

You are invited to participate in a study on lawyer's experience of representing clients under the Mental Health Act. The study is being undertaken by Anshita Thakkar, a Masters in Health Science student at the University of Auckland. Her supervisors are Dr Kate Prebble (UOA) and Dr Katey Thom.

The title of the study is: Lawyers' perspectives on barriers and facilitators to providing effective legal representation to service users under the Mental Health (Compulsory Assessment and Treatment) Act (MHA) 1992

Please see attached a Participant Information Sheet and Consent Form. If you want more information about the study or wish to participate, please contact the researcher or her supervisors. Their contact details are listed in the Participant Information Sheet.

This message has been sent to all lawyers on the Auckland and South Auckland mental health legal aid roster. If you know other lawyers who are representing mental health clients in a private capacity, please forward the information to them.

Kind regards

Ben Thomson

Administrator for Auckland and South Auckland mental health rosters and Secretary to the Mental Health and Disability Law Committee

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS
ETHICS COMMITTEE ON 18/04/2016 FOR (3) YEARS, REFERENCE NUMBER 017308

Appendix E: Participation Information Sheet (Auckland District Law Society Mental Health and Disability Committee)



**MEDICAL AND
HEALTH SCIENCES**
SCHOOL OF NURSING

Faculty of Medical and Health Sciences
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The University of Auckland
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Auckland 1142
New Zealand

PARTICIPANT INFORMATION SHEET (Auckland District Law Society Mental Health and Disability Committee)

Project Title: Lawyers' perspectives on barriers and facilitators to providing effective legal representation to service users under the Mental Health (Compulsory Assessment and Treatment) Act (MHA) 1992

Name of researchers: Anshita Thakkar, Dr Kate Prebble and Dr Katey Thom (supervisors)

Research Introduction

My name is Anshita Thakkar; I am a Masters of Health Sciences student at the University of Auckland's Faculty of Medical and Health Sciences. As part of this qualification, I am undertaking a qualitative research project that will result in a thesis. The duration of this project is from March 2016 to February 2017. The study sits within a body of research undertaken by my supervisors on mental health legislation, rights and advocacy in New Zealand. This research will explore lawyer's perspectives on barriers and facilitators to providing effective legal representation to service users under the Mental Health (Compulsory Assessment and Treatment) Act (MHA) 1992. I will be interviewing lawyers to gain insights in this area and ask for suggestions on how legal representation could be improved to protect better and advocate for service users' rights in the future. This project will focus on three legal proceedings: The Section 16 review (s. 16), the compulsory treatment order hearing (s. 28), and reviews by the Mental Health Review Tribunal (MHRT) (s. 79). The findings could inform a broader study on legal representation under the MHA including an exploration of service users' experience.

Project Description and Invitation

The research aims to:

- i. Explore lawyers' perspectives on positive aspects of providing legal representation
- ii. Explore lawyers' perspectives on challenges to providing effective legal representation

- iii. Identify dilemmas experienced by lawyers in providing effective legal representation to service users
- iv. Understand how lawyers overcome challenges to providing effective legal representation to service users
- v. Identify recommendations on training and support for lawyers to work with people with mental disorders and enhance their practice under the MHA
- vi. Identify recommendations for legislative reform related to MHA formal legal proceedings that will enhance just outcomes for service users.

I am requesting your assistance in advertising this research to mental health lawyers in the Auckland area. If you are agreeable, your organisation would be involved by sending out information on behalf of the research team to lawyers. This research has the potential to improve understanding of the limits and potential of legal representation under this Act and providing recommendations on how to enhance the advocacy of service users in the future. The findings may also assist with reviews of legal training and enhance lawyers' ability to recognise and respond to vulnerabilities within the legal system. It may also guide legal processes and procedures that can be delivered more effectively to service users while maintaining public safety needs.

Recruitment Procedure

Auckland District Law Society's Mental Health and Disability Committee (the committee) will forward an email, a participation information sheet and consent form which has been prepared by the research team to mental health lawyers on the committee's Auckland and South Auckland legal aid roster. These documents are attached, for your information. The committee will not be informed about who has participated in the study.

You may also choose to receive a copy of the summarised findings of the research once it has been completed. Please provide your email address on the consent form if you wish to receive a report of the findings.

Contact Details and Approval

Student Researcher name and contact details	Supervisors names and contact details	Head of Department name and contact details
Anshita Thakkar Atha037@aucklanduni.ac.nz	Dr Kate Prebble School of Nursing, The University of Auckland k.prebble@auckland.ac.nz 923-3413 Dr Katey Thom School of Nursing, The University of Auckland k.thom@auckland.ac.nz 923-9579	Judy Kilpatrick Department Nursing j.kilpatrick@auckland.ac.nz 373-7599 Ext. 2897

For any queries regarding ethical concerns, you may contact the Chair, The University of

Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 ext. 83711. Email: ro-ethics@auckland.ac.nz.

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS
ETHICS COMMITTEE ON 18/04/2016 FOR (3) YEARS, REFERENCE NUMBER 017308

Appendix F: Consent Form (Auckland District Law Society Mental Health and Disability Committee)



**MEDICAL AND
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The University of Auckland
Private Bag 92019
Auckland 1142
New Zealand

CONSENT FORM

Auckland District Law Society Mental Health and Disability Committee

THIS FORM WILL BE HELD FOR A PERIOD OF 6 YEARS

Project Title: Lawyers' perspectives on barriers and facilitators to providing effective legal representation to service users under the Mental Health (Compulsory Assessment and Treatment) Act (MHA) 1992

Name of Researchers: Anshita Thakkar, Dr Kate Prebble & Dr Katey Thom (supervisors)

I have read the Participation Information Sheet, and I have understood the nature of the research. I have had the opportunity to ask questions and have had them answered to my satisfaction.

- I agree to send out information about the research to mental health lawyers on the committee's Auckland and South Auckland legal aid roster on behalf of the research team.
- I understand that ADLS Mental Health and Disability Committee will not be informed about who has participated in the study
- I understand that the consent form will be kept for 6 years, after which they will be destroyed.
- I wish/ do not wish to receive a summary of the research findings (please circle).
- Please provide an email address if you wish to receive a report of the findings:

Name: _____

Signature _____ Date _____

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS
ETHICS COMMITTEE ON 18/04/2016 FOR (3) YEARS, REFERENCE NUMBER 017308

Appendix G: Participant Information Sheet (Lawyers)



**MEDICAL AND
HEALTH SCIENCES**
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Private Bag 92019
Auckland 1142
New Zealand

PARTICIPANT INFORMATION SHEET (Lawyers)

Project Title: Lawyers' perspectives on barriers and facilitators to providing effective legal representation to service users under the Mental Health (Compulsory Assessment and Treatment) Act (MHA) 1992

Name of researchers: Anshita Thakkar, Dr Kate Prebble and Dr Katey Thom (supervisors)

Research Introduction

My name is Anshita Thakkar; I am a Masters of Health Sciences student at the University of Auckland's Faculty of Medical and Health Sciences. As part of this qualification, I am undertaking a qualitative research project that will result in a thesis. The duration of this project is from March 2016 to February 2017. The study sits within a body of research undertaken by my supervisors on mental health legislation, rights and advocacy in New Zealand. This research will explore lawyers' perspectives on barriers and facilitators to providing effective legal representation to service users under the Mental Health (Compulsory Assessment and Treatment) Act (MHA) 1992. I will be interviewing lawyers to gain insights in this area and ask for suggestions on how legal representation could be improved to protect better and advocate for service users' rights in the future. This project will focus on three legal proceedings: The Section 16 review (s. 16), the compulsory treatment order hearing (s. 18), and reviews by the Mental Health Review Tribunal (MHRT) (s. 79). The findings could inform a broader study on legal representation under the MHA, including an exploration of service users' experience.

Project Description and Invitation

The objectives of this study are to:

- i. Explore lawyers' perspectives on positive aspects of providing legal representation
- ii. Explore lawyers' perspectives on challenges to providing effective legal representation
- iii. Identify dilemmas experienced by lawyers in providing effective legal representation to service users

- iv. Understand how lawyers overcome challenges to providing effective legal representation to service users
- v. Identify recommendations on training and support for lawyers to work with people with mental disorders and enhance their practice under the MHA
- vi. Identify recommendations for legislative reform related to MHA formal legal proceedings that will enhance just outcomes for service users

You are invited to participate in this research because you work in mental health law. You may have received this invitation via the Auckland District Law Society's Mental Health and Disability Committee. The Committee will not be informed about who has participated in the study.

Your participation in this research is entirely voluntary. If you are interested in participating or want more information, please contact one of my supervisors or me (see contact details below).

Project Procedures

If you indicate that you want to participate, I will contact you to arrange a convenient time and place for the interview to take place.

Before the interview begins, I will briefly explain the project verbally. You will then be asked to sign a consent form to indicate that you are happy to participate and that you are doing so voluntarily. The interview will take approximately one hour (up to one and a half hours). You may refuse to answer any questions during the interview. You also have the right to stop the interview at any time without giving a reason.

With your permission, the interview will be audio-recorded. If you agree to be recorded, you may choose to have the recorder turned off at any time without giving a reason. The audio-recording of the interview will be transcribed by me or by a transcriptionist who has signed a confidentiality agreement. If you wish to read the transcript, it will be sent to you soon after the interview. You may revise or delete any part of the transcript within two weeks of receiving it.

Interviews will take place between May and July 2016. You have the right to withdraw from the research at any time until 1st September 2016 without giving a reason. If you choose to withdraw from this research transcripts and audio recordings will be destroyed immediately

How will the information be used?

Interview data will be used to inform a master's thesis. The findings may also be used in academic articles and conference presentations.

You may also choose to receive a copy of the summarised findings of the research once it has been completed.

Risks and Benefits

It is not anticipated that this research will cause discomfort. There is a risk that you could be recognised by readers because of the small number of lawyers who work in mental health law in the Auckland area. I will endeavour to minimise this risk by attending to issues of confidentiality (see below).

You may find participation in this research beneficial. You will have the opportunity to share your experiences of providing legal representation to service users under this Act. The finding of this study will contribute to a greater understanding of the barriers and facilitators to providing effective legal representation for mental health service users. This has the potential to influence policy, practice and education.

Confidentiality

Information given as part of this research will remain confidential between you, the researcher and supervisors. It will only be used in this study.

Your name and any other identifying details will be removed from the transcripts and future publications or presentations that draw on the data. In the outputs from this research, you will be referred to by a pseudonym or number.

Data Storage, Retention, Destruction and Future Use

Maintaining the privacy of your information is important. Transcriptions, handwritten notes, and consent forms will be kept securely at the University of Auckland. The digital audio files will be kept in password-protected folders on the University of Auckland server. Only the researcher and supervisors will have access to this information. Information that could identify you will not be in writing. The audio recordings will be destroyed at the end of this project. All written data will be kept for a period of six years in alignment with University of Auckland data storage policy. After this time, transcripts, consent forms and other information will be destroyed.

You may also choose to receive a copy of the summarised findings of the research once it has been completed. Please provide your email address on the consent form if you wish to receive a report of the findings.

Contact Details and Approval

Student Researcher name and contact details	Supervisors names and contact details	Head of Department name and contact details
Anshita Thakkar Atha037@aucklanduni.ac.nz	Dr Kate Prebble School of Nursing, The University of Auckland k.prebble@auckland.ac.nz 923-3413 Dr Katey Thom School of Nursing, The University of Auckland k.thom@auckland.ac.nz 923-9579	Judy Kilpatrick Department Nursing j.kilpatrick@auckland.ac.nz 373-7599 Ext. 2897

For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 ext. 83711. Email: ro-ethics@auckland.ac.nz.

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS
ETHICS COMMITTEE ON 18/04/2016 FOR (3) YEARS, REFERENCE NUMBER 017308

Appendix H: Consent Form (Lawyers)



**MEDICAL AND
HEALTH SCIENCES**
SCHOOL OF NURSING

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Facsimile 64 9 367 7158

The University of Auckland
Private Bag 92019, Auckland 1142
New Zealand

CONSENT FORM

Lawyers

THIS FORM WILL BE HELD FOR A PERIOD OF 6 YEARS

Project Title: Lawyers' perspectives on barriers and facilitators to providing effective legal representation to service users under the Mental Health (Compulsory Assessment and Treatment) Act (MHA) 1992

Name of Researchers: Anshita Thakkar, Dr Kate Prebble & Dr Katey Thom (supervisors)

I have read the Participation Information Sheet, and I have understood the nature of the research and why I have been selected. I have had the opportunity to ask questions and have had them answered to my satisfaction.

- I agree to take part in this research. I understand that this will involve my participation in an individual, face-to-face interview that will last approximately an hour (up to one and a half hours).
- I understand that my participation is voluntary and I am free to withdraw at any time until 1st September 2016 without giving any reason.
- I have been informed of the risks and benefits of participating in this study.
- I understand that any identifying details will be removed from the interview transcriptions/notes and that I will not be named in any of the research outputs.
- I understand that ADLS Mental Health and Disability Committee will not be informed about who has participated in the study.
- I understand that though I may agree to be audio taped, I may request for the audio tape to be turned off at any time without giving a reason.
- I understand that I have the opportunity to receive transcripts of my interview and make any revisions up to 2 weeks after receiving the transcripts.

- I understand that the recording of the interview will be destroyed at the completion of the thesis.
- I understand that the transcripts and consent forms will be kept for 6 years, after which they will be destroyed.
- I understand that if I choose to withdraw from this research transcripts and audio-recordings will be destroyed immediately.
- I wish/ do not wish to receive a copy of the transcript (please circle).

I wish/ do not wish to receive a summary of the research findings (please circle)

- Please provide an email address if you want your transcript or a report of the findings: _____).

Name: _____

Signature _____ Date _____

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS
ETHICS COMMITTEE ON 18/04/2016 FOR (3) YEARS, REFERENCE NUMBER 017308

Appendix I: Interview Schedule

INTERVIEW SCHEDULE

The purpose of this research is to understand lawyers' experiences of providing representation to MHA patients. The interview will be semi-structured and broadly follow the questions set below. Lawyers will be questioned about the challenges and positive aspects of providing representation to mental health patients, including preparing for and providing advocacy in hearings (s. 16 review, s. 18 compulsory treatment order hearing, and Mental Health Review Tribunal / MHRT). The topic areas that will be explored are represented below. Prompts will only be used if needed. Participants may choose not to answer questions. As the interview progresses, some questions may be omitted depending on participant responses. The interview will take approximately 1 to 1 ½ hours long depending on how questions are answered.

Demographic Information:

The following information will be provided to interview participants to fill out on a separate sheet of paper prior to the interview.

- Age
- Gender
- Ethnicity

Lawyer's background

- How long have you worked as a lawyer?
- When did you become involved with mental health? What interested you in this field?
- Approximately what proportion of your work is in mental health law?

Roster and Access

1. How do you come into contact with patients under the MHA?
2. If any, what challenges do you experience accessing mental health patients?
3. Do you have any ideas about how access to legal representation could be improved?

The next 4 topics consist of questions which are associated with four broad topic areas: preparation for each hearing, communication with clients, meeting clients' objectives and needs and providing representation in the hearing or review procedure itself. Where relevant, participants will be asked about the differences in providing advocacy in three hearings (s. 16 reviews / s. 18 compulsory treatment order hearings/ MHRT)

Preparation for the hearing/ review

4. How do you prepare for hearings under the Mental Health Act?
5. If any, what challenges do you encounter preparing for the [hearing]?

Prompts:

- time constraints, funding, access to services

Communication with clients

6. What difficulties do you experience communicating with clients before or during [hearing]? How does this impact your practice?

Prompts:

- level of acute illness; ESOL; cultural expectations; clients' knowledge of legal processes;
7. How do you overcome communication difficulties?
 8. Do you have any ideas about how communication with clients could be improved in the future?

Prompts:

- Training; Presence of a family member or translator

Meeting clients' objectives/needs

9. How would you define effective/optimum representation in the [hearing]?

Prompts:

- What do you aim to achieve in the [hearing]? (for the client or for the court)
 - Is there a difference when your client agrees/ disagrees to treatment? Please explain/ provide an example.
10. What are the challenges or barriers to providing optimum representation?
 11. What facilitates you to provide optimum representation? What makes a successful [hearing]?

Challenges and facilitators during the hearing

12. What challenges do you experience providing representation during hearings?

Prompts:

- Cross-examining medical evidence, patient participation, involvement of other parties, limited power of hearings etc.
13. How do you overcome challenges to providing representation during hearings?
 14. In your opinion, what makes a successful [hearing]? Could you provide an example?

Recommendations for future procedural and legislative reform

15. Do you have any ideas about how changes in practice or the system could improve the legal representation of mental health patients?
16. If any, what recommendations do you have for legislative reform that would enhance legal representation under the MHA?

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 18/04/2016 FOR (3) YEARS, REFERENCE NUMBER 017308

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