

## Therapeutic Appellate Decision-Making in the Context of Disabled Litigants

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Traditionally, courts, and even specialist tribunals, have not catered well to important components of the audiences for their decision-making. While notable in the context of first instance decision-making, this problem has been particularly pronounced at the appellate level. Assuming that most of those who will read the actual version of their determinations will be lawyers, courts have often indulged in impenetrable legalese. Further, where litigants are disadvantaged in terms of their ethnicity or culture, their command of English, or their faculty for understanding by reason of a mental illness or intellectual disability, courts have made minimal compromises to the mode of communication to assure that litigants understand the decisions. There are many reasons why this is objectionable, not the least of which is because it serves to alienate one of the key parts of the legal system—the judges, magistrates, and tribunal members—from the remainder of the community. It disenfranchises those who often most need to understand what is being decided about them and how the decisions involving their personal circumstances are made.

An example highlights the issue well. A key element of both the criminal and tort law systems is to deter, to hold people's conduct as exemplary of what ought not to be done in a civilized and ordered community. The notions of "general deterrence" in the criminal domain and "exemplary" or "punitive damages" in the area of torts involve a message from the courts that certain conduct is unacceptable and that penalties will be imposed if comparable conduct is replicated. However, such messages have no chance of achieving their objective if

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the judgments in which they are found are not intelligible and accessible.

Traditionally, the rationales asserted for "legal speak" were the complexity of the subject matter being dealt with and the need for precision. However, the "plain English movement" of the 1970s and 1980s revealed the spuriousness of these rationales, the truth being that skilled writing and communication for the most part can make intelligible what is otherwise complicated and even outside the bounds of ordinary experience.<sup>1</sup> But there is another reason that the subject-matter of judgments and decisions, both appellate and first instance, should be communicated effectively. It is important that the parties, especially those that lose, understand the reasons and the reasoning for the ultimate decision. Only the most perverse of losing parties are happy when a decision goes against them. In order for members of the community to continue to avail themselves of the legal system to solve their interpersonal problems rather than resorting to extra-legal self-help solutions, they need to be able to feel, at the conclusion of a case, that they have received a fair hearing. While they may not be happy with the result, they need to be able to appreciate why it is that the resolution has been reached and regard the process as having been unbiased and reasonable. In addition, wherever reasonably practicable, the way in which the determination is expressed should not be such as to precipitate adverse consequences for the disabled litigant or witness.

Where people with physical or mental illnesses or with intellectual disabilities or brain damage are litigants or witnesses, this is equally important. If they depart from their cases feeling demoralized by or disenfranchised from the process, this can be profoundly counter-therapeutic. One of the most significant contributions of the therapeutic jurisprudence movement has been the dawning of awareness amongst a percentage of decision-makers internationally that the legal system should, so far as possible, be pro-therapeutic in both its decisions and its processes, from the hearing of cases through to the delivery of judgments and decisions.<sup>2</sup> This has a range of important consequences for how those with disabilities are dealt with by the legal system at the trial and appellate level. This Article explores ways in

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1. See, e.g., LAW REFORM COMM'N OF VICT., *LEGAL RIGHTS AND PLAIN ENGLISH* (1986); LAW REFORM COMM'N OF VICT., *PLAIN ENGLISH AND THE LAW* (1987).

2. See, e.g., T.R. Tyler, *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings*, in *LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE* (David Wexler & Bruce Winick eds., 1996); Nathalie Des Rosiers et al., *Legal Compensation for Sexual Violence*, 4 *PSYCHOL. PUB. POL'Y & L.* 433 (1998); IAN FRECKELTON, *CRIMINAL INJURIES COMPENSATION: LAW, PRACTICE AND POLICY* (2000).

which appellate decision-making can be enhanced so as to minimize the counter-therapeutic consequences of the curial process for litigants and witnesses with psychiatric illnesses and intellectual disabilities.

### I. CHARACTERISTICS OF THE APPELLATE PROCESS FROM A LITIGANT'S POINT OF VIEW

Litigation at the appellate level has a tendency toward being rarefied. The questions at issue often interpret statutory provisions or grapple with reconciling or distinguishing previous court judgments. These issues can be abstruse and technical, the product of combing by appellate practitioners in search of even the slightest error in the first instance decision-making. Sometimes appellate litigation can involve *de novo* rehearings or the calling of further evidence. More often, though, the appeal requires analysis of an inferior judgment to determine whether it was made against the evidence or contrary to legal principle.

In the quest for rectitude of the application of law, and of law to fact, there is a temptation for advocates and appellate decision-makers to fail to take into account the parties to the litigation. Whereas there is an inescapable sense of immediacy in trial litigation, at the appellate level, it is easy to fail to have continuing regard for the reality of the parties and the special needs of particular categories of parties.

Many litigants report the appellate process to be significantly more alienating and disorienting than their first exposure to litigation at trial. They often feel that they are not adequately consulted and that they do not understand the process or the potential for adverse or unsatisfying outcomes. The reason for these feelings is the subject-matter of the discourse between bench and bar, and the comparative irrelevance in terms of evidence of the parties. The evidence upon which appellate courts focus was given in a lower court or tribunal. Errors and omissions cannot be corrected at the appellate level. This means that the subject matter of conferences between clients and legal advisers is usually confined to the merits of instituting the appeal.

A recent appellate decision in Victoria, Australia, involved the resolution of an application for an intervention order to keep one person previously involved in a domestic relationship away from another; the decision-maker accepted, on review, the claims of a woman with a mental illness. However, he inadvertently gave the impression that he disbelieved aspects of her claim about having been anally raped by the person against whom she sought the order. In spite of succeeding in her appeal, the litigant responded by attempting to commit suicide.

One should always be careful about drawing systemic inferences from a single instance. However, this tragic example highlights the need for all persons involved in the legal process, including the appellate process, to be particularly careful in their language and manner when dealing with persons with mental illnesses or intellectual disabilities. Otherwise, the results can be devastatingly counter-therapeutic.

## II. LITIGATION INVOLVING PERSONS WITH INTELLECTUAL DISABILITIES

Where a litigant or witness is intellectually disabled and the decision is not as he or she would like it to be, a variety of adverse sequelae *can* follow if the process that reached the determination was flawed. Judicial narrative theory has highlighted the fact that distortions and shifts in focus occur in relation to the players in the litigation process.<sup>3</sup> The prism of personal experience is different for those with disabilities, though.

The experience of being a litigant or a witness generally has particular resonances for those with intellectual disabilities.<sup>4</sup> Until many aspects of our system improve, it is probable that there will be substantial gaps in what litigants with intellectual disabilities understand, and, that what these litigants feel themselves to understand will have particular qualities not experienced by other litigants.

Take, for example, a person with an intellectual disability for whom time periods and multisyllabic words are problematic. All too many lawyers are incapable of putting their questions in a straightforward way, either in direct examination or in cross-examination. Many trial and appellate judges and tribunal members suffer from the same affliction—due to a lack of training and a vocational lifetime in which such skills have not been developed (and have had little perceived value). The result for the person with an intellectual disability can be an experience of pervading perplexity, bewilderment, and distress. Ambiguities within concrete language and arising out of the use of idiom or difficult dichotomies make the task of saying what they want to communicate much more difficult than it is for the ordinary witness. In addition, courts and tribunals are often intimidating places, especially those where appellate litigation is conducted.

The whole process is confusing and alienating for most litigants, and even more so for those who have extra hurdles to overcome. If a

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3. See Thomas Faunce & Bernadette McSherry, *Chinese Whispers: Judicial Narratives and the Regulation of Clinical Medicine*, 4 J. L. & MED. 326 (1997).

4. See, e.g., TRAUSTADOTTIR & K. JOHNSON, WOMEN WITH INTELLECTUAL DISABILITIES: FINDING A PLACE IN THE WORLD (2000).

result is contrary to what a disadvantaged litigant expects, it can seed the anxiety that because of his disability he has been misunderstood, thereby entrenching a sense of failure and inadequacy that many intellectually disabled persons feel already. It can also further alienate and embitter the litigant.<sup>5</sup>

### III. LITIGATION INVOLVING PERSONS WITH MENTAL ILLNESSES

For persons with a mental illness, many of the same concerns arise regarding understanding the process, whether they are involved as witnesses or as litigants. Those who suffer from delusions, hallucinations, significant mood lability, personality disorders, or paranoid ideas are especially susceptible to further difficulties. They too experience the litigation process through the prism of their illness. That prism can be significantly distorting in relation to what people do and why they do it.<sup>6</sup> The result of such confusion can further that person's sense that he or she is "other" than those within the community, that he or she is being discriminated against, or that there is no hope for his or her recovery from illness. All of these responses have the potential to entrench symptomatology and to make both chemical and cognitive-behavioral intervention more difficult.

For this reason, it is appropriate for decision makers, curial or para-curial, to be attuned, on their part and on the part of advocates, to those aspects of process and communication that can be counter-therapeutic. By such consciousness, there is the potential for the litigation system to avoid acting to the detriment of the health of litigants and witnesses and even to advance such persons' health. This is as equally so in appellate litigation as it is in first instance cases.

### IV. VICTORIAN MENTAL HEALTH REVIEW BOARD EXPERIENCE

In making suggestions in this regard, the author draws upon his experience of having sat as a decision-maker on issues of civil commitment on Victoria's Mental Health Review Board in Australia. The author has also sat on the Medical Practitioner's Board and Psychologists' Registration Board of the same state, disciplining doctors and psychologists who were found to have committed improprieties (all too often in the sexual area against clients). The Article also draws on many years experience as an advocate for persons with intellectual disabilities and mental illnesses. The court system could learn from the

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5. See also T. CARNEY & D. TAIT, OFFICE OF THE PUBLIC ADVOCATE, BALANCED ACCOUNTABILITY (1992).

6. See, e.g., *R. v. Taylor* [1992] 11 OR.3d 323 (Can.) (noting that "unfit to stand trial" means that the defendant cannot conduct his or her defense on account of mental disorder).

experience of decision-making bodies that, as their staple, deal with the circumstances of those with mental illnesses or intellectual disabilities—bodies that deal with appeals from clinicians' decision-making about the involuntary status and rights of those involuntarily detained, or bodies that appoint persons to look after the affairs of those with disabilities.

The Mental Health Review Board of Victoria, Australia ("the Board") is an inquisitorial body that was created by statute in 1987.<sup>7</sup> It inquires, amongst other things, into whether a person should continue to be detained involuntarily within a psychiatric hospital or within the community as a patient.<sup>8</sup> In most hearings, the Board consists of three members: a lawyer, a psychiatrist, and a representative of the general community. In order to promote its accountability and transparency, the Board's decisions are formally reported in a series of published reports.<sup>9</sup>

Although, of course, there is a degree of variability of practice amongst the members of the Board, the Board has sought a consistency of approach by articulating values and developing processes for the conduct of its hearings and the delivery of its decisions. The aim of the processes and philosophies embraced by the Board is to promote the mental health of the patients whose affairs it inquires into, while still fulfilling its statutory mandate to make just, quick, and fair decisions based on the evidence before it.

A number of practices of the Board attempt to advance its philosophical objectives of patient empowerment and the promotion of the health needs of patients, as well as correct resolution of the legal and factual issues that it has the responsibility to determine. First, in the course of any given hearing, the practice of the Board is for members to speak directly to the patient as much as possible. This involves something of a downgrading of the traditionally adversarial role of the legal representative. This is consistent with the essentially inquisitorial role of the Board.

The way in which members of the Board elicit this information from patients is also important. It does not follow that because a person has a mental illness and/or an intellectual disability that he or

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7. Mental Health Act, 1986 (Austl.).

8. See IAN FRECKELTON, VICTORIAN CRIMINAL LAW, INVESTIGATION AND PROCEDURE (2000); Ian Freckelton, *Decision-Making About Involuntary Detention: Victorian Practice*, 5(2) PSYCHIATRY, PSYCHOL. & L. 249, 259-61 (1998); Phillip A. Swain, *Admitted and Detained—Community Members and Mental Health Review Boards*, 7 PSYCHIATRY, PSYCHOL. & L. 79, 81 (2000); I. Gardner, *Mental Illness—Freedom and Treatment*, in M. IONES & LAB MARKS, EXPLORATIONS ON LAW AND DISABILITY IN AUSTRALIA, (2000).

9. THE MENTAL HEALTH REVIEW BOARD DECISIONS OF VICTORIA (Aust.).

she is therefore insensitive. The opposite is frequently the case. The individual will be quite keenly attuned to people "speaking down" to him, or to people being condescending or patronizing. Patients often find this particularly offensive and distressing. It is simply that there are certain kinds of language with which they are likely to deal unsatisfactorily or from which they may draw adverse inferences. This has ramifications for the terminology that should be used and the attitudes that should be communicated in the course of a hearing, both by those making the decisions about civil commitment and by those providing information to the Board. This is so in both decision-making and in the conduct of proceedings generally.

Active measures are taken from the outset of a hearing to make the patient feel as comfortable as possible within the context of a hearing. Apart from a matter of simple decency, this is important in terms of the Board's capacity to exercise its function and also to make the hearing experience as constructive as can be managed. Hearings take place within hospitals and community mental health centers. If the patient feels at ease, better still. If the patient can establish some rapport with at least one member of the Board, the information provided by the patient will be of a higher quality, and the Board's decision will be the better for it. The patient will also feel that he has acquitted himself before a body external to the clinicians at the hospital or mental health center where he is treated, and his self-esteem and sense of achievement may well be enhanced by the experience. In the context of the care of persons with mental illnesses, such considerations are important in terms of health outcomes. All too often the legal system fails to acknowledge the public interest over and above the correct resolution of the legal dispute—for instance in advancing the litigant's state of health.

Members of the Board individually introduce themselves to the patient and the patient is then asked how he or she would like to be addressed. This avoids stilted formality and also the taking of what might be perceived as liberties with the person's identity—Miss, Mrs, Sir, John, Jane, etc. Then a discussion takes place between the person detained and the presiding member in which it is explained to the person why the hearing is taking place and what its outcomes can be. If the patient has questions, they are answered. Obviously, control has to be maintained by the Board. Generally, however, the existence of interchanges at a relaxed level between the Board and the person detained are not problematic in this regard. The key is establishing a friendly and unimposing dynamic, accompanied by the maintenance of a level of solemnity and formality that communicates to the patient

that the process is regarded by the decision-makers as important and careful.

Information is obtained from key persons, such as doctors, nurses, psychologists, and often family members, always in the presence of the patient, provided he or she is well enough.<sup>10</sup> The legal representative for the patient, if there is one, is allowed to ask questions, but the representative is encouraged not to be too adversarial. Usually, if representatives have significant criticisms to make regarding the clinicians' conclusions or methodologies, this can be done without hostilities breaking out. This is important because at the end of the hearing, the patient may well remain at the institution or continue to be treated by the same doctor or nurse at the mental health center. If the relationship of trust and confidence that the clinicians have worked hard to create is destroyed by the process of challenge to the patient's status, it may or may not secure the patient's liberty, but it will have consequences that are disadvantageous for the patient in the broader picture. Board members intervene consistently in an attempt to prevent this from happening, while at the same time trying to minimize interference with the way in which patients or their advocates wish to conduct their case and say what they want. The line is a fine one, but it is very important.

The patient is told at the start of proceedings that what he or she has to say about the situation is of particular interest to the Board and that the Board wants to hear from the patient. For the most part, evidence is elicited not by the traditional direct examination through the patient's counsel, if he or she is legally represented, but by members of the Board asking questions. After the Board has finished with its questions, the doctor is often allowed to pose questions to the patient. After that, the patient's advocate, if there is one, is given the opportunity to elicit information regarding specific issues the advocate wishes to highlight.

The questions posed by the Board usually yield the most extensive part of the information provided by the patient. The substance and the form of the questions is designed not to intimidate or worry patients, but to elicit the patient's understanding of matters such as why the patient was detained, how the patient was before being taken into detention, what the patient thinks of the medication that he or she has been given, how the patient feels, whether the patient believe he or she has an illness that needs treatment, whether the patient perceives that the treatment is causing side-effects, what the patient would do if

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10. Occasionally, persons who are seriously psychotic or who suffer from severe dementias do not fit within this category.



he or she were not being coerced into treatment, and what the patient would like to have happen in terms of his or her care. It is important that such questions, so far as possible, not be "closed" and that they not be argumentative or convey that a preliminary position has already been adopted by the Board.

In New Zealand, Du Fresne has helpfully drawn attention to the potential for the involuntary commitment hearing to act in a constructive way for the patient.<sup>11</sup> Much depends upon process and impression. Even if the patient is unsuccessful in his application to be released, the hearing has the potential to be an empowering, paranoia-reducing, and confidence-building process. If the patient emerges from the hearing disappointed, but feels that he has been treated fairly and with dignity, given an opportunity to air grievances, and listened to by a body that has considered all that the patient has said and the arguments that have been advanced on his behalf, it can make a significant difference to the patient's mental state. Rather than feeling that he is sequestered in an environment in which no one will listen and in which the detention is open-ended, the patient can emerge with an awareness that he has somewhere to appeal and that someone will listen if the patient feels that something wrong or contrary to his interests has been done, even if the patient is currently regarded as mentally unwell. The fact that an independent body will take the time to undertake this exercise is often significantly pro-therapeutic for patients. If the Board does the job well, this is particularly so.

Naturally, it is the Board that regulates the procedure in the hearings that take place before it. A key aspect of the potentially pro-therapeutic aspect of the process is the way in which the doctor responsible for the detention of the patient expresses his or her views and is cross-examined by the patient or the patient's legal representative. Again, this is significantly within the control of the Board. Doctors are directly questioned by the members of the Board. They are encouraged to be frank, low-key, and constructive in what they say. This often affects the ongoing dynamic of the patient-doctor relationship. The doctor's thinking about the patient is under the microscope. Difficult questions are often asked by the Board and by, or on behalf of the patient, about the need for detention, the symptomatology of the patient, and the doctor's considered treatment plans for the patient. Frequently, the patient will disagree with what the doctor says and will interrupt, lucidly or otherwise. The Board generally allows leeway in terms of such interactions directly between the

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11. Stephanie Du Fresne, *Preparation and Presentation of Medical Evidence for Civil Commitment Hearings*, 3 J. L. & MED. 256, 259-61 (1996).

patient and the doctor, whether or not the patient is represented. Often, something of a clinical interchange takes place before the Board.

These interactions can be of considerable assistance to the Board. Not only does the Board gain insight regarding how the patient is really doing, but the interactions also provide an opportunity for a frank and important discussion under external oversight between the doctor and patient about the parameters, aims, and plans of treatment. The Board hearing can actually provide a forum for this, which ordinary clinical interaction does not allow. Sometimes the Board intervenes and says that the discussion should take place later. On other occasions, it allows the interchange to proceed, aware that uncertainties in the patient's mind may be in the process of being resolved or that confusions or misunderstandings that may previously have characterized the clinical relationship are in the process of being sorted out.

Multiple hearings are always scheduled for the Board, meaning that the time during which any given hearing can be undertaken is limited. It is vital, however, that a patient not perceive that his or her case is being pushed through a sausage machine, or that his or her individual circumstances and problems are not being given individual consideration. The Board endeavors to balance the need for efficient management of a substantial case load with the creation of an atmosphere consistent with the patient (and the doctors) being confident that what he or she communicates to the Board is being taken into account and carefully considered. The reality and appearance of haste are avoided as much as possible, and flexibility is maintained with regard to the time allocated to cases.

From the point of view of the patient, the decision of the Board is likely to be the most remembered part of the Board's activity. It has four distinct audiences to which it needs to cater. The most important audience is the patient, as well as the patient's family and support persons. The second is the medical staff who must also emerge from the hearing comfortable that it has been heard, recognized, and understood. The staff must feel that its clinical work is valued and supported, but also that it is accountable for its actions and opinions. It is important for patients and medical staff alike to emerge with an awareness that the clinical decisions must be consonant with the legislation that regulates the detention of persons with mental illnesses. The third audience is the appellate body that may have cause to scrutinize the decision of the Board to determine whether it was legally correct. The fourth audience is those individuals who later may have reason to

read the decision of the Board and to evaluate how the reasoning process applies to their case, or to their client or patient's case.

In almost every case, an oral decision is given by the Board after it takes time for short deliberation in the absence of the patient and doctors. The oral decision is delivered directly to the patient in the presence of the doctors and anyone else who the patient would like present. It is given by the legally qualified member of the Board. Styles differ among members somewhat. However, the guiding principles generally adopted by members are that the decision, as much as possible, should be delivered in a positive tone and should be encouraging, whatever the outcome. It should be communicated in plain English, avoiding the use of unnecessarily technical language of a medical or legal character. It should not be unduly lengthy, rehearsing every aspect of the information provided to the Board, because the attention spans of patients are not always prolonged. It should not keep the patient in suspense. Rather, the decision should indicate the result and then give the supporting reasons clearly. It should be robust and clear, but should not offend or needlessly distress the patient by intruding into sensitive matters in a way that will adversely impact the patient's self-esteem or recovery from the symptoms of mental illness. Where the information provided to the Board indicates that the patient's journey through the mental health system is significantly under way, this writer's practice is to stress, wherever possible, that involuntary detention has an end-point and that while the Board may not be able to identify that point with precision, the patient has made significant progress toward regaining and resuming his previous role in the community.

The patient is also informed that he or she has a right to a written version of the reasons for the decision, and that there is a right to an appeal. When the written decision is constructed, again, a compromise is sought between enunciating correct legal principle and explicating reasons that will be meaningful and accessible to the patient.

## V. DISCRIMINATION AND STIGMATIZATION

Particular responsibilities weigh upon appellate decision-makers when writing decisions involving health issues and vulnerable litigants or witnesses. First, it is important that courts not perpetuate or inappropriately tap into discriminatory attitudes harbored by some about issues such as mental illness or intellectual disability. If they do, they bring the law into intellectual disrepute, stereotype categories of participants in the legal system, and entrench misunderstandings within the wider community. They can also cause considerable distress and

anger for litigants and witnesses. Courts that use unsatisfactory terminology and express views that might be seen as judgmental can legitimize ill-informed prejudices within the general community.

Because of the potential for such adverse consequences, appellate decision-makers should call upon counsel to educate them about issues that may not be within the experiential bailiwick of appellate courts. This information should not be translated into modish or politically correct judicial rhetoric, but into a measured and informed analysis of the issues. The language employed in appellate decision-making should be accurate and should not arouse or enhance adverse attitudes within the general community about issues that are emotive and that can be fear-inducing or prejudice-causing. Ideally, judgments at the appellate level should serve an educative function about issues such as the dangerousness of those with mental illnesses and intellectual disabilities. Appellate courts have the potential to assist in enhancing community awareness of such issues, reducing misinformation and prejudice.

Further, the way in which an appellate judgment is framed has the potential to significantly impact individual litigants—sometimes in ways that cannot be easily predicted. If a judgment releases confidential details of a patient's health profile, or speaks insensitively or critically about a litigant or witness with a mental illness or an intellectual disability, it can have a range of adverse therapeutical ramifications for the person involved and those associated with the person.<sup>12</sup> The sequelae can include stigmatization of the patient and a number of counter-therapeutic consequences for the patient's care and recovery.

In this regard, cloaking vulnerable people in anonymity can be an important consideration. This initiative can be successful at a broader level by suppressing the name of the litigant or witness, thereby preventing media portrayal of the actual person in a way that enables the litigant or witness to be recognized by those who might not otherwise know him or her. However, there is another dimension to the issue. It is important for appellate decision-makers to be conscious of the fact that the identity of the person will be well-known to those in contact with him or her, particularly within relevant institutions (such as psychiatric hospitals, health care centers, and residences for persons with intellectual disabilities), and that what is said about the person, and how it is expressed, can have a range of important consequences for the institutional reputation that the individual acquires. In turn, this

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12. See for instance the New Zealand example of J. Coverdale et al., *A Legal Opinion's Consequences for the Stigmatisation of the Mentally Ill: Case Analysis* 7 PSYCH., PSYCHOL. & L. 2 (forthcoming 2000).

can impact how the person is regarded within his or her environment, how the person is spoken of by staff and co-residents, how the person's files are maintained, what priority the person has for privileges and transfers, and the kind of contact the person is permitted with the general community.

## VI. WAYS FORWARD

Litigation involving persons with disabilities takes place in many different contexts: civil, criminal, matrimonial, and administrative, to name just a few. However, all legal contexts share the potential to demoralize, alienate, and entrench symptoms of suspicion, bewilderment, and disenfranchisement for those with disabilities. Much could be learned from specialist inquisitorial bodies with an expertise in dealing with this category of litigants. The opportunity exists to develop procedures and modes of communication that are more accessible for this important category of participants in the litigation process. Such initiatives need not significantly reduce the traditional attributes of the adversary process or impair the fairness of the court process. Rather, they have the potential to draw upon some of the flexibilities of the inquisitorial process, resulting in an improved quality of evidence and even in a pro-therapeutic experience for this vulnerable cross-section of the community.

Such changes to procedure are perhaps even more pertinent to appellate proceedings than to those that are conducted at first instance. The more legalistic nature of typical appellate proceedings imposes a particular responsibility upon the appellate court or tribunal to communicate sensitively with the person with a disability so that the person is facilitated in his or her understanding of what the proceedings deal with, what the patient's role in the proceedings is, and the process by which the proceedings are likely to be resolved. By utilizing the practices of bodies such as the Victorian Mental Health Review Board, and by judicial education about disability issues, this can be done readily enough by injecting a degree of informality and extra sensitivity into the communication, and if in open court, without the intervention of lawyers in the exchange between those presiding and the person with the disability.<sup>13</sup>

While this will undoubtedly consume a small amount of extra time, both in the process and in the delivery of the decision, and while it can constitute some small encroachment upon traditional aspects of the adversary system, it has the potentially constructive consequences

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13. Although, of course, lawyers should still be present.

of involving the person with a disability in the litigation process and communicating to the person the approach and understanding of the appellate body.

Another initiative to consider is the provision by courts at the appellate level, as well as at first instance, of a "support person" for the litigant with a disability. The Psychologists Registration Board in Victoria routinely provides such a person for complainants who make allegations of impropriety against their treating psychologist. It has proved to be very helpful in terms of making the proceedings less burdensome and more comprehensible for persons who are often very vulnerable and quite distressed. There is no reason why such a source of support and, in effect, translation could not be provided for persons with mental illnesses or intellectual disabilities when they are involved in appellate proceedings. Aside from providing both ongoing explication of procedures and arguments at the appellate level, it should be part of the role of such a support person to read the judgment of the court with the disabled person and, if necessary, to make it available in summary, readily understandable form. Occasionally, this may require legal assistance. For the litigant with a disability, such measures can transform the appellate process from an alienating and confusing exercise to one in which the litigant feels a sense of involvement in the process and outcome. While the proceedings may not be pro-therapeutic, at least they have the potential to be less counter-therapeutic.