BOOK REVIEWS

Australian Mental Health Tribunals

(by **Terry Carney**, **David Tait**, **Julia Perry**, **Alikki Vernon** and **Fleur Beaupert**, Themis Press, 2011)

Very few first-rate empirical studies are published of legal proceedings in Australasia. But here is one – an excellent socio-legal work on mental health tribunals in Victoria, New South Wales and the ACT. These tribunals, like their New Zealand counterpart, review the status of compulsory psychiatric patients and have the power to discharge them from control under the Mental Health Act. The conclusions of this study contain many lessons, and much to celebrate, concerning the work of the New Zealand tribunal, which already adheres to many of the study's recommendations, even if, resources allowing, there is more that could be done.

Carney and colleagues used a mixed method approach to examine the work of the tribunals from several angles. They conducted a study of the files of the consumer (or patient, or client) hearing records of the three tribunals, using their data management systems, showing case flows, and outcomes of the hearings, and other relevant performance indicators of the review process. They also conducted extensive interviews with a selected sample of consumers, carers, and other key informants, including members of tribunals, and the psychiatrists, lawyers and lay advocates who appear before them. Then extensive observations were made of actual tribunal proceedings.

A study on this scale is difficult to fund and manage. A raft of regulatory and ethical clearances is required, along with the consent of participants. This required numerous research partnerships to be formed, and several years' fieldwork. But, in good time, all this is drawn together nicely in a well-produced book.

The main conclusion the authors draw about the work of these tribunals in southeastern Australia is the need for considerably more resourcing, so tribunals can devote more time to each case (the average length of many hearings observed was about 20 minutes). Tribunals need a broader jurisdiction, they say, to permit them to consider not only the consumer's compulsory status, but aspects of treatment, including the adequacy of the treatment plan, and to consider the question of inpatient versus outpatient care. There needs to be greater preparation, on the part of all parties, for the hearing, greater sharing of information, better access to legal representation, and more attention to debriefing the consumer when the outcome of the hearing is known. Senior clinicians, with the best knowledge of the consumer's condition and care, plus family members, should be encouraged to attend. The physical or architectural space for the conduct of hearings needs improvement. More information should go before the tribunal on the consumer's social circumstances, in addition to

the medical evidence. Hearing procedure should permit the consumer's "voice" to be more fairly heard. Overall, greater administrative support is needed for tribunals, and greater integration of their functioning into the governance of the state-level mental health system.

Critical problems identified were under-funding, excessive case-loads, brevity of hearings, non-attendance by senior clinicians, low levels of legal representation, and a general lack of structural support. So, despite the dedication of many individual tribunal members, there was much to improve.

The book is rather slow to gather steam. The introductory chapters take a hundred pages, but much of this material is valuable. It provides a good overview of the states' mental health legislation, and of human rights principles, prior research on mental health review tribunals in Britain and North America, and the reasons why we need independent review, by a multi-disciplinary body, of compulsory treatment decisions. The methods followed in each of the three sub-studies are then explained; the results are presented, including extensive quotes from participants; conclusions are drawn; recommendations are made; and a full bibliography and appendices on method complete the work. In total, the book is an outstanding example of the full presentation of socio-legal work.

One aspect of the analysis that stands out concerns the inevitable tensions that arise between the expectations of the different participants in tribunal hearings, between those of clinicians and consumers, for instance. There is clearly the potential for the proceedings to be harmful, even cruel, to the consumer, in certain respects, even if beneficial to them in others. The narrative reveals the extraordinary difficulties (or binds) consumers face if they try to contest the evidence of the clinicians that they are mentally ill. Their attempt to deny their illness will not only be rejected by the tribunal as contrary to the uncontradicted evidence of the clinical team, it may also be viewed as lack of insight into their need for treatment, and therefore as a sign of their lack of capacity to consent to treatment. So it will not only fail to contradict the view that they are mentally ill, but will also count as evidence that they meet several other legs of the legal criteria. As the authors put it (at 215):

> The consumer is a central figure in the hearing, but sometimes seems to be treated as an exhibit, in that their performance and behaviour at the hearing is judged as evidence pertaining to their mental illness. Thus the tribunal might appear to be listening to the content of the evidence, but in fact are (understandably) also assessing the consumer's evidence in terms of symptoms.

How could it be otherwise, when a person's speech and conduct are the main means through which mental illness is assessed, and when there is usually no psychiatric evidence presented to support the consumer's own view?

There is continuing tension also between the need for the tribunal to be satisfied that the legal criteria are met and the need to maintain the dignity of the consumer in the process. Collaboration is the key to good

treatment, but the hearing process may require a clinician to present the consumer's history in the worst possible light, dredging up past acts of violence or self-harm, for instance, and downplaying progress in treatment, to ensure continuation of compulsory status. This occurs in front of the consumer, and in front of the tribunal and various other parties who happen to attend, appearing from the consumer's point of view to be a monstrous breach of privacy in front of strangers. And yet, from another point of view, this is all necessary to ensure evidence is given in front of the consumer to comply with the principles of natural justice.

Ultimately, this study, like all others, finds that tribunals apply the legal criteria governing compulsion in a flexible and pragmatic way, and very few consumers are discharged. But that may not mean the process has no value. In particular, the process may have important preventive effects, when many more consumers are discharged directly by clinicians in the days immediately before the hearing is due.

As to the implications of this study for New Zealand: it is a mistake, it shows, to equate frequency in tribunal hearings with rigour in the review process. Frequent hearings produce high caseloads for the tribunal, and this leads to a perfunctory process. Overburdened caseloads may lead in turn to demands for reduction in the size of the tribunal – from a three- to a one-member body, for example – producing more tribunals with fewer members, so spreading the work around. That change, however, subverts the greatest strength of the tribunal process – its multi-disciplinary character. And it will reduce substantially the participation of psychiatrists on tribunals. Yet, in most cases, only a psychiatrist has the knowledge and standing to interrogate rigorously the evidence of treating clinicians.

New Zealand would be unwise to go down that path. We are well-served by current arrangements, under which the review functions for compulsory patients are shared between judges of the Family (or District) Court, in the early stages of the process, and a properly-constituted Review Tribunal that can provide more intensive review, of fewer cases, further down the track. District Inspectors are also available in all regions to advise patients on their review entitlements. Many patients before the tribunal seem to be legally represented. The Responsible Clinician, who has the best knowledge of the patient's treatment, usually seems to attend. The patient's evidence is usually heard first, so the tribunal does not seem to be unduly biased by the clinicians' opinions before the patient has their say. Then, when the clinicians have spoken, the patient seems to have the opportunity to respond. The tribunal rarely seems to conduct more than a few hearings in one day, providing adequate time, unlike New South Wales, where 15 or more hearings (many on the telephone) might be conducted in one day.

The final message for New Zealand of this fine Australian study, therefore, is about the need to value the relative rigour of the New Zealand review process for compulsory patients, where the labour is

shared between the courts and tribunals, and where it is supported by the work of District Inspectors and lawyers representing patients on legal aid. This process has served us well for 20 years. We should defend it, while continuing to improve it, by taking seriously the many sensible suggestions of Carney and his colleagues.

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