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CENTRE FOR MENTAL HEALTH RESEARCH

Balancing individual rights with public safety

The decision-making of the Mental Health Review Tribunal

Katey Thom, Stella Black and Graham Panther

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES
School of Nursing

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1 Introduction

New Zealand's legislation is underpinned by policy decisions that should ensure the protection and promotion of the human rights of individual citizens (Human Rights Commission, 2005). In certain circumstances, however, civil rights and liberties have to be weighed against the State's obligation to protect individuals and to ensure public safety, a balancing act exemplified in such contexts as counter-terrorism law (Chesney, 2003; Cole & Dempsey, 2002; Heymann, 2002; Lobel, 2003-2004; Wilson, 2005), government sanctioned surveillance practices (Fyfe & Bannister, 1996; Mitchell, 2003) and the legal detainment of individuals for psychiatric assessment and treatment.

Within the context where people are being compulsorily assessed and treated for a mental disorder, promoting the individual's civil liberty and welfare interests while protecting community safety becomes a core challenge (Diesfeld & Freckelton, 2003). The Mental Health Review Tribunal (MHRT) aims to provide safeguards for service users by ensuring their right to be free from unjustified detention or treatment (Brookbanks, 2005). The MHRT functions as an independent body that reviews compulsory treatment orders for people with mental illnesses. It provides an important safeguard for service users by ensuring their right to be free from unjustified detention or treatment (Brookbanks, 2005).

Similar tribunals overseas that provide independent review have been subject to much criticism in the literature (Carney, 2011; Carney, Tait, Chappell, & Beaupert, 2008; Gostin & Fennell, 1992; Myers, 1997; R. O'Brien, Komer, & Dunbar, 1999; Perkins, 2003a). There is limited research in New Zealand, however, that has systematically considered the decision-making of the MHRT, and the effectiveness of the MHRT has not been investigated since its implementation in 1992. Such empirical insights are crucial given current debates taking place regarding reform of current mental health legislation.

This project, funded by The University of Auckland Faculty Research Development Fund, set out to explore the decision-making processes of the MHRT. The project aimed to provide 'thick descriptions' (Geertz, 1973) of the MHRT process, by closely focusing not only on the content of final written decisions, but also *how* decisions are made and delivered within the context they are formed. These descriptions were then placed within the wider social, legal, political and international milieus in order to understand the constraints that shape the decision-making of the MHRT. A final aim of the project was to consideration the implications of the overall findings for the applicants and professionals involved with the MHRT.

This report details the key findings from the project. More detailed analysis of the research data will be presented in a series of academic papers to be published shortly.

2 Methodology

The project employed a qualitative approach to studying the MHRT. A qualitative approach to research "explores and describes social phenomena about which little is presumed a priori" (Giacomini, 2001: 4) and generates insights into particular practices, experiences and social settings. In contrast to quantitative approaches, qualitative studies do not anticipate the effects of predetermined variables. Rather, the aim is to understand life from the perspective of the participants within their social context.

We employed five methods of data collection. These included: systematic review of literature, semi-structured interviews, non-participant observation, and collection statistical data and legal texts. Together, these methods allowed us to explore the MHRT *in action,* or as it happened, rather than retrospectively relying on re-collective interviews and documentation only.

2.1 Systematic review of literature

A systematic review of literature published in journals, sections of books, and online papers was undertaken to explore what is currently known about tribunals that function similarly to the MHRT internationally. Only literature describing the results of *original* quantitative or qualitative studies published between March 1960 and March 2012 were included. Letters, case law review, whole books, news items and unpublished manuscripts and papers discussing conceptual issues were excluded from the systematic review.

A search strategy was developed that was inclusive of a wide range of literature. Search terms were used to search the online databases MedLine, PubMed, PsychInfo, Web of Science, JSTOR, Expanded Academic, Project muse, Academic Research Library, Brookers online, and the search engine Google Scholar. Bibliographies were reviewed to identify other articles of interest. We also searched for literature written by key authors in the area. Publications were then assessed for relevance by two researchers independently. Each article or report had to meet the set criteria of assisting in answering a minimum of one of the following research questions: What factors appear important in the decision making of tribunals? What difficulties do tribunal members face when making their decisions? What changes can be made to improve tribunals? (i.e. legal reform, practice change). In cases where there was disagreement between researchers, consensus was reached by discussion.

2.2 Semi-structured Interviews

Semi-structured interviews were sought with all current members of the MHRT from April 2011 to October 2012. Fourteen members agreed to take part in the study. Two members were interviewed twice following the observations of MHRT hearings. All but two interviews were conducted face-to-face and the interviews lasted on average one hour.

The first interview canvassed topics related to the different tasks assigned to members, the MHRT process (preparation, hearing process, and deliberation), training and induction for the role, difficulties associated with the role and MHRT process, the relationship between statutory criteria and decision-making, MHRT outcomes, and the future of MHRT. The second interview with members focussed on topics that emerged following the first round of interviews, observation of MHRT hearings and systematic review of international literature. These interviews focussed on any issues that need further clarification and provided members with an opportunity to respond to the research team's interpretations of different aspects of the MHRT decision-making processes following observations.

2.3 Non-participant observation

The research team conducted several observations of hearings to gain further insights into the decision-making and the general operation of the MHRT. There were two specific aims to using this method. First, by observing hearings the research team sought to further acquaint themselves with MHRT processes. Second, observation of the MHRT "in action" was sought to add to the findings from the interviews. Observational methods, in particular, have been found to be extremely effective for investigating in-depth the 'everyday' functioning of roles and interactions between individuals (Latour, 1987; Latour & Woolgar, 1979) and have been used in previous studies of similar tribunals internationally (Peay, 1989; Perkins, 2003a). Applied to this project, this method, combined with the interviews, generated insights into the roles of members, the difficulties they face, and the interactions between legal and medical professionals in this context.

The research team aimed to observe a variety of settings in which the MHRT operates, including: inpatient and forensic hospitals, and community mental health centres in Auckland, Hamilton and Christchurch. The Auckland region was selected because of the high numbers of MHRT hearings that take place there, and the Waikato and Christchurch regions were added to supplement the data collection by allowing for consideration of regional variation. The observations took place over six months in the latter half of 2011 and beginning of 2012.

A total of 11 hearings were observed over the six months. This low number of observations was largely due to the complex procedure of gaining consent from applicants prior to the hearings. Due to the sensitive nature of the hearings the team could not avoid or simplify these procedures. Nevertheless, the research team believes that the observations yielded enough information to contribute significantly to the key findings of the study.

Not all aspects of the MHRT decision-making were observed, with research team members leaving the hearing with all other attendees during deliberation. In 8 cases, the research team was given permission by the panel and applicant to audio record the hearings and in all cases detailed field notes were systematically collected while the hearing proceeded.

2.4 Statistical data

A de-identified copy of the database which D'Ath Partners maintains on the applications was obtained. This allowed for a detailed descriptive statistical analysis to be completed on the characteristics of the MHRT hearings over time, giving a broader context to situate the findings of this study.

2.5 Legal texts

The full written decisions of the MHRT were collected over the 6 months in which observation of the hearings took place, supplementing the field notes and providing a written record of the MHRT decision-making and reasons for that decision. A total of 60 written decisions were analysed. Case law that was referenced in the written decisions and discussed in the interview data was also sourced.

2.6 Data Analysis

2.6.1 Systematic review of literature

Owing to the diverse nature of the included studies, the content of all papers was also synthesised and a table of studies was drawn up to assist in the synthesis of literature. A template modelled on Hawker et al.'s (2002) framework was then used to critically appraise the

methodological rigour of the published studies. This model was chosen because it provides a method to critically appraise published studies using operational criteria that can easily be applied to studies using diverse methodologies. Nine variables relating to the published studies were appraised, including: abstract and title; introduction and aims; methods and data; sampling; data analysis; ethics and bias; results; transferability or generalisability; implications and usefulness. Each paper was then given an appropriate weighting of 'good', 'fair', 'poor' or 'very poor', with a score of 10, 20, 30 or 40, respectively, for each variable. These determinations were combined to give an overall maximum score of 360 for methodological rigour.

2.6.2 Qualitative analysis

An inductive approach was used to analyse the qualitative data thematically. The team began this process of analysis with the interview data. The final interviews transcripts were read and re-read by three members of the research team independently to gain an understanding of key themes that were significant across the data corpus. This involved searching for patterns of repeated themes that were relevant to the objectives for the project. An analytical framework was then developed by the team collaboratively and used by one member of the team to then purposively code the interview data.

This process was then repeated with the data collected through the observations and the written decisions of the MHRT. The repetition of such analysis, ensured the development of an comprehensive analytical framework through a process of triangulation. Triangulation refers to the process whereby the researcher, rather than relying on one single form of evidence or perspective as the basis of analysis, employs various methods to gather a wide variety of evidence which is used to check the validity and reliability of the research results. Although the same biases in data collection may still be present, because there are more types of evidence being analysed, there are more reference points to check the validity of the overall results.

To differentiate qualitative data through this report we have presented sources differently. Verbatim interview extracts have been indented and font formatted as *italics in blue*, observational data is contained within highlighted blue boxes, and excerpts taken from written decisions indented and formatted in blue font. In the presentation of all qualitative data, the research team have been careful to protect the anonymity of all parties involved in MHRT work and hearings. Pseudonyms replace all names of those who took part in a hearing or interview during the study and any other identifying features were deleted or anonymised (e.g. mental health service, location of hearing).

2.6.3 Descriptive statistical analysis

The MHRT database was extensively cleaned by two members of the research team. This process included checking and fixing data entry errors (e.g. spelling mistakes, relocating data to correct columns) and also devising new variables to make the descriptive analysis meaningful (e.g. adding a category for 'year' rather than dates, adding age ranges, and assigning District Health Board regions to cases). Basic descriptive analysis was then completed using the cleaned database. Due to the small success rate of applications, predictive statistics could not be completed.

2.7 Advisory Committee

An advisory committee oversaw the project. Professor Warren Brookbanks provided the necessary legal oversight of the proposed project. Professor Brian McKenna and Associate Professor Kate Diesfeld provided the expert advice for investigating the MHRT. Paul Hannah-Jones participated as a practising lawyer with extensive experience in representing applicants before the MHRT. Due to the private nature of material canvassed in the MHRT, which may

include culturally sensitive information, it was imperative to ensure project was conducted in an ethically and culturally appropriate manner, sensitive to the needs of applicants. In the development of this proposal consultation took place with Gareth Edwards and Debra Lampshire, service user academics, and Dr Rees Tapsell, a Māori consultant forensic psychiatrist who has extensive experience in the MHRT and who currently holds a position as the Executive Clinical Director of the Midland Forensic Psychiatric Service.

2.8 Ethics

This study involved researching a tribunal that is private in nature and involves the consideration of sensitive information regarding a vulnerable individual. In addition, because of the small population of New Zealand, the maintenance of the anonymity of both the applicant and confidentiality of information in this context could be made difficult. As such, the ethical issues related to undertaking this project were carefully considered and were subjected to review by the Northern X/Y Health and Disability Committee (ref number NTY/10/12/098).

*

The presentation of the findings in this report aims to provide a snapshot of the MHRT decision-making process founded on the experiences and perspectives of the participants in this study, a selection of written decisions and observations of a selection of hearings, and data held in the MHRT database. The report is not intended to function as a definitive account of the MHRT.

3 The legal framework

The primary role of the MHRT is to review the condition of people subject to compulsory treatment orders, special patient orders, and restricted patient orders. Reviews are conducted under sections 79-81 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 ('the Act'). Section 79 of this Act allows for reviews of people subject to compulsory inpatient treatment orders or community treatment orders. Under sections 80 the MHRT reviews people subject to forensic disposition as special patients, and under section 81 reviews restricted patients. There are several other functions of the MHRT (See Dunlop, 2013 for further details and commentary). However, this report is concerned with decision-making under sections 79-81 only, but primarily section 79.

The MHRT does not conduct reviews of all patients subject to compulsory treatment, special or restricted orders. Reviews are only instigated as a result of application being made to the MHRT. Applications for review by the MHRT can be lodged by the applicant themselves or via their welfare guardian, primary caregiver, lawyer or district inspector. The MHRT also has the power to review the condition of a patient on their own motion (see s76(7-9) of the Act). In most cases, however, applicants are received from patients (Dunlop, 2013). The MHRT, therefore, only reviews the condition of a small proportion of people who are at any one time subject to compulsory treatment, special and restricted orders.

The role of the MHRT under section 79 is to determine whether or not an applicant is fit to be released from compulsory status. That determination involves assessing whether or not the applicant is mentally disordered within the meaning of the Act – as follows:

> **mental disorder**, 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

A decision of the MHRT that the applicant is no longer mentally disordered results in him or her being found fit to be released from compulsory status, and the applicant must be released immediately.

Decisions under section 80 regarding applicants who have a forensic disposition under a special patient order are not determinative as is the case with section 79 decisions. Final decision-making lies in the hands of the Minister of Health or the Attorney General. Different rules again apply to MHRT decisions under section 81 in relation to restricted patients.

The MHRT travels around the country to conduct hearings in the mental health service where the applicant is receiving their treatment. Each case is heard by a panel comprised of three MHRT members – a lawyer, psychiatrist and community member. The Minister of Health appoints members to the MHRT. Membership comprises three core members who are assisted by deputy members. The most recent annual report of the MHRT states there were six lawyers, 10 psychiatrists and three community members, giving a total of 19 members. In a small number of cases, a fourth member may be co-opted for a particular reason, such as ethnicity.

Interpreters may also be involved in hearings, but are not party to decision-making (Mental Health Review Tribunal, 2012).

On average a hearing lasts around 1 ½ hours and can be attended by the applicant, the applicant's lawyer, the responsible clinician, the key worker, family members and support persons and other health, cultural, or social care professionals. A district inspector may also attend the MHRT hearings and most applicants are represented by a lawyer on a legal aid basis.

The MHRT hearings are an inquisitorial rather than adversarial in nature, with each attendee being questioned in turn by the members. The Tribunal processes aim to balance the rights and interests of the applicant and those of the wider public, while at the same time aiming to enhance rather than damaging therapeutic relationships:

> *In a great majority of cases, the Tribunal's decision is contrary to that sought by the applicant and so an effort is made to provide the applicant with constructive and positive comment by way of support and encouragement. Tribunal members seek to conduct hearings in such a way as to enhance rather than damage therapeutic relationships. On the other hand, the process is quasi-judicial, involving the determination of the rights and interests of not only the applicants but other persons as well (Mental Health Review Tribunal, 2010, p. 11).*

The MHRT attempts, therefore, to practise in a way that mimics the principles of therapeutic jurisprudence in the acknowledgement of its potential to assist in the production of positive consequences facilitated through providing support, encouragement and procedurally fair processes. Running alongside these processes, is the core focus on the rights and interests of both the applicant and the wider public.

4 International context

This section of the report summarises our systematic review of studies on the decision-making of tribunals similar to the MHRT. For a full account of this review, please refer to our published paper 'Mental Health Review Tribunals in action: A systematic review of empirical literature' (2013), *Psychiatry, Psychology and the Law,* DOI:10.1080/13218719.2013.790004.

4.1 Profile of studies

Of the 7,845 citations initially identified, 50 papers met the inclusion criteria. The final sample reviewed included 43 peer-reviewed journal articles, three book chapters, two online reports, and two non-peer reviewed journal articles. The majority of papers (70%, n=35) presented data from United Kingdom, with seven papers discussing data originated from Australia, four from New Zealand, two from Canada and one from Ireland. One study did not specify the country of origin. Over a half of the studies were quantitative in design (n=28, 56%), however, a variety of data collection methods were employed overall. In 36% (n=18) of studies the decision making of members was the major focus of the study.

4.2 Synthesis of literature

After repeated readings, the literature was synthesised into distinctive themes on various aspects of the decision making by tribunals.

4.2.1 Extra-legal factors prominent

The studies reviewed suggested that factors outside the strict wording of laws governing tribunals were often crucial to members' decision-making, often as a result of the blurring of legal and non-legal factors that occur in this context. The non-adherence to strict laws of evidence in the decision-making of the tribunals, coupled with a tendency for opinion, intuition, 'rules of thumb' and subjective feelings about the right course of action to precede fact, was also highlighted in many studies (Diesfeld & McKenna, 2005; Diesfeld & Sjōstrōm, 2007; Perkins, 2003b; Richardson & Machin, 2000c; Roberts, 1995). In one study, it was reported that the tribunal's rules were frequently circumvented to protect the patient's 'best interests' (Peay, 1981). Studies also illustrated that members at times struggled to understand, and therefore chose to ignore the court-imposed meanings of concepts such as 'insight', 'compliance', 'treatability', 'psychopathy' or 'nature or degree' in examining the factual evidence since they were discordant with their own preferred meanings (Diesfeld & McKenna, 2005; Perkins, 2003b; Richardson & Machin, 2000b), despite the fact that these concepts were reported by members themselves as key to decision-making (Perkins, 2003a). Finally, many studies have reported that tribunals rely on a 'back to front' decision-making process (Brockman, 1993, p. 212) where the members first determine what outcome they prefer and then select the evidence to accord with that view (Peay, 1989).

4.2.2 The health context dominates

Many of the studies have described how the decision-making of tribunals privileges medical opinions. These studies have concluded that tribunal decisions are based on a psychiatrist's perception of what the patient needs rather than the strict application of legal tests (Carney, 2010; Hepworth, 1983; Mohan, Murray, Steed, & Mullee, 1998; Peay, 1989; Perkins, 2003a; Richardson & Machin, 2000a; Shah, 2010).

In particular, studies have found the *source*, rather than *content* of evidence matter most in tribunal decision-making (Peay, 1989). In a mock tribunal set-up, Peay (1981) found that it was

the responsible authority's report that exerted the greatest influence on the eventual direction of members' decisions. Peay's (1981) findings were confirmed in later studies that have indicated clinical reports are the most influential factor in the members' decision-making (Roberts, 1995). In one study, for example, tribunal decisions to detain mentally disordered offenders in maximum security were best predicted by clinical opinions, particularly those of senior clinicians (Hilton & Simmons, 2001). A statistically significant level of agreement between mental health clinicians and members regarding decisions about community treatment order discharges was also found in another study (Jaworowski & Guneva, 2002). Observations of tribunal hearings by Richardson and Machin (2000b) showed that the three most frequently asked questions (in 88-90% of observed cases) related to diagnosis, mental health symptoms and co-operation with treatment. Once introduced, this clinical focus persisted throughout much of the hearing with discussions revolving on detailed discussion of the patient's care, treatment and future plans. Diesfeld and Sjōstrōm (2007) found that in two out of the total of six discharge decisions they reviewed mentioned medical submissions about 'lack of insight' without indicating the members' exact position. In one study, legal representatives reported their struggle to challenge medical evidence presented to tribunals (Campbell, 2008) and, in another, the majority of patients perceived the responsible clinician's opinion to hold the most weight in deciding the outcome of hearings (Dolan, Gibb, & Coorey, 1999).

It is important to note that two studies reported that the outcomes of hearings may not necessarily be predicated on medical evidence. O'Brien et al., (1995) found no significant difference in the outcome of hearings in which the responsible clinician was or was not present, despite the responsible clinician being present in 88% of the hearings. Additionally, a study by Hilton and Simmons (2001) indicated that the availability of an empirically validated actuarial risk assessment report did not substantially influence tribunal decisions to release forensic patients from maximum security.

4.2.3 'Dangerousness' and 'risk' most important

Assessment of dangerousness and risk were key factors in most decision-making by tribunals (Fleming, 1963; Hepworth, 1983; Peay, 1989). This may be problematic when members do not necessarily have an agreed understanding of 'dangerous behaviour', as Peay (1981) found in her study whereby it was evident from the range of behaviours included under this term (e.g., confusional states, embarrassing or incompetent behaviour) that not all members were applying it in a similar manner. In cases where an applicant had committed a dangerous act in the past, members became more conservative in their decision. Finally, Dolan, Gibb and Coorey (1999) found that 54% of surveyed patients in a psychiatric hospital in England indicated that they thought that the tribunal was not 'independent' as it was too easily influenced by evidence of continued risk to the public.

4.2.4 Going beyond their jurisdiction

Several studies observed members extending their decision-making beyond the statutory boundaries of the tribunals (Carney, 2010, 2011; Diesfeld & McKenna, 2006; Hepworth, 1983; Peay, 1981; Richardson & Machin, 2000a, 2000b). This was particularly evident where there was lack of sufficient evidence and was manifested in many ways. Tribunals have been seen to be taking an interventionist approach regarding clinical decisions even though this was beyond their legal authority, including how medical treatment is administered, directing clinicians to seek alternative forms of treatment and advising clinicians on the application and availability of specific medication (Diesfeld & McKenna, 2006). It is important to note, however, that Richardson and Machin's (2000b) analysis of questions put to medical witnesses during hearings indicated that an examination of the statutory criteria can unavoidably lead to a wider discussion of patients' current care and future treatment plans.

4.2.5 The marginalisation of lay members

Studies have suggested that the alliances between legal and medical professionals may lead to the marginalisation of lay members' voices during proceedings (Peay, 1981, 1989; Richardson & Machin, 2000a; Swain, 2000). Peay's studies (1981, 1989) showed that legal and medical members' opinion together, and especially medical opinion (even if dissenting) had more influence on the direction of the group decision than the lay members'. Lay members themselves indicated that they felt that their contributions were less useful and that they had to guard against the medical member carrying too much influence (Richardson & Machin, 2000a; Swain, 2000). Seen from the patients' perspective, legal representatives and lay members of the panel were not reported as having any major influence on the proceedings (Dolan, et al., 1999).

Swain's (2000) observation of tribunals also demonstrated that lay members were the least active participants within hearings; they asked fewer questions than other members and their pattern of involvement mirrored that of psychiatric members. Lay members tended to be at their most active in exploring the details of the applicant's case and in ensuring that the applicant understood the process or the issues being raised, although even here the legal member was still the most involved.

The literature also pointed to a degree of vagueness about what the role of the lay member should entail or what their contribution to the tribunal should be. Cavenagh and Newton's (1971) study involving interviews with members details no specific personal qualities for recruitment of lay members; 'merit' was singled out as the main conscious criterion. Interviewees stated that the lay member was present primarily to 'watch over the interests' of the application by being an 'ordinary' citizens rather than being there because of their affiliation with a certain profession. At the same time, however, the study reported interviewees as stating that the lay member should 'play a full part' and 'stand up to the professionals'.

Despite the noted marginalisation and role ambiguity of lay members, their medical and legal colleagues have also reported that they contribute vital knowledge and skill to hearing processes, especially in regards to judgments about the behaviour, functioning or beliefs held by an applicant (Swain, 2000). Lay members have also been perceived as better skilled at dealing with aggressive, distressed or uncommunicative applicants. Without their presence, the legal and medical members suggested their decision-making and the hearing processes would more likely become legalistic, formal and dominated by psychiatric understandings of behaviour (Swain, 2000).

4.2.6 Experiences of powerlessness

Carney's (Carney, 2010, 2011) comprehensive accounts of applicants' experiences have demonstrated that some feel confused, distressed, anxious, powerless, and dissatisfied with tribunal procedures. Although many applicants and carers acknowledged applicants were given the opportunity to speak, Carney found they did not feel that members took their evidence into account when making final decisions. Many advocates and carers commented that it is vital that applicants do not perceive that they are being 'talked about' more so than being engaged in the discussion. Carney describes how the dissatisfaction with hearings was exacerbated by communication problems experienced by the applicants due to the use of technical medical terms by members. Also, applicants' poor education, lack of English language proficiency, general anxiety and experiences of mental distress and/or drug side-effects added to their difficulties in communicating effectively, reducing their ability to participate fully in the hearings and increasing their sense of powerlessness. Some applicants reported feeling intimidated after hearing the treating team's case and others commented that members were 'cold' or did not appear to respect their evidence. Overall, Carney's studies (2010, 2011) indicated members demonstrated a more favourable view of the tribunal than the applicants.

These findings mirrored those of earlier studies by Ferencz and McGuire (2000) and Ferencz (2003) where applicants to the tribunal described a 'cycle of distress' (powerlessness, dissatisfaction, communication problems in relation to detention, confusion, distress, and expectations of the tribunal). Applicants also experienced dissatisfaction with character of the setting, akin to the court room environment (including the large numbers of people present in the hearing, the setup of the room, large size of the table and positioning of the members opposite the applicant). In a study by Dolan, Gibb and Coorey (1999), 39% of surveyed applicants to the tribunal reported being totally satisfied with their last hearing and felt that they had the opportunity to put their point across. However, 29% were totally dissatisfied. In the same study, 56% of applicants reported that they felt the tribunal format was too formal and intimidating and indicated that they would prefer an informal case-conference style meeting. Respondents in Carney's (2011) study suggested switching to a more inquisitorial style hearing where a solution was negotiated, and the view that the hearings should be held in a more comfortable setting was mirrored by carers and mental health lawyers in a different study (Campbell, 2008).

4.2.7 Enhancing therapeutic outcomes

Despite the dissatisfication exposed by some applications, tribunals' efforts to encourage the communication and collaboration between the applicants and members of the multi-disciplinary care team emerged as a theme in several studies. Richardson and Machin (Richardson & Machin, 2000b) observed that in 52% of hearings, members discussed the way forward for the applicant with their clinical team and attempted to say something positive to the applicant wherever possible. Perkins (2003b)(2003b) observed that tribunals frequently provided an opportunity for improvement to the therapeutic outcomes for the applicant, despite the final decision not always being favourable to them. Diesfeld and McKenna (2006) found that slightly over a half of tribunals' written decisions referenced the enhancement of the therapeutic relationship and the vast majority provided applicants with constructive and positive comment 'by way of support and encouragement'. Similarly, Yip (2004) found that 63.2% of surveyed psychiatric hospital physicians and social workers agreed that review panels served as a buffer when there was disagreement between the patients and the treatment teams about their release. Just under half (48.7%) believed that review panels encouraged patients to work collaboratively with their treatment teams for a release in the future, and the majority (77.8%) agreed that review panels gave patients a sense of control over their hospitalizations. This view was confirmed by another study (O'Donoghue et al., 2010) where more than a half of involuntary patients reported the tribunals to be fair system in which to review involuntary admissions, with just under half (45.5%) of them finding it easier to accept their admission when their case was reviewed by a tribunal.

4.2.8 Inadequate legal representation

Many studies reported inadequate legal representation of applicants (e.g., Carney, 2010, 2011; Swain, 2000). It has been demonstrated that significantly more applicants who are legally represented are discharged by the tribunals (Blumenthal & Wessely, 1994). However, Swain (2000) found a frequent absence of legal representation in hearings, with applicants being represented in only 2 out of 25 hearings. Although in O'Brien et al's (1995) study 69% of applicants were represented by a lawyer, having legal representation did not significantly increase their chances of successful discharge. Indeed, Diesfeld and McKenna (2007) found that some written decisions of the tribunal indicated that applicants' lawyers did not vigorously advocate on their behalf, especially when applicants had an intellectual disability. Examples of problematic advocacy by members in Carney's (2011) study included descriptions of situations where it was not clear during the hearing whether the legal representative was acting on instruction from the applicant or acting on their own perceptions of the applicant's best interests. This is in stark contrast to the views expressed by legal representatives in the same

study who argued that their role was to "*uphold consumers' right to have their viewpoint put articulately, regardless of its merit*" (Carney, 2011, p. 147). Campbell (2008) found that the small number of solicitors he surveyed displayed a generally superficial understanding of mental health law; they also commented on the lack of training and educational infrastructure available to them.

4.3 Summary

This systematic review found a diverse body of research on the tribunals. Despite significant jurisdictional and procedural differences in the workings of these bodies internationally, eleven prevailing themes common to the reviewed studies were identified. These are largely related to the shortfalls of the current tribunal systems in at least five Western countries.

Overall the empirical evidence suggested tribunals are largely dominated by health perspectives, with studies suggesting hearings act as 'rubber stamps' for medical opinions and decision-making plagued by the 'rules of thumb' largely revolving around assessment of dangerousness. Clinical evidence was also found to be the preferred evidence by tribunals, despite its overall low quality. The absence of legal representation or non-clinical evidence was found in many studies to contribute to the overreliance on clinical evidence.

Differences in the perspectives of applicants and members on the quality of the hearing process were evident from a number of studies. Applicants were generally more critical of the tribunal system, citing issues around the procedural fairness of hearings. Not being heard due to poor communication with members, inadequate legal representation and/or feeling intimidated by an essentially adversarial hearing, were among the main reasons for the hearings not being perceived as honest and/or legal robust by the applicants across numerous studies (Carney, 2010, 2011; Dolan, et al., 1999; Ferencz, 2003; O'Donoghue, et al., 2010; Perkins, 2003b; Swain, 2000; Topp, Thomas, & Ingvarson, 2008). Although studies have reported lay members of the tribunal being perceived as valuable in bridging the gap between the medico-legal perspectives and the applicants' voices, there was a general consensus that their participation in hearings is minimal and their views largely marginalised in tribunal decision-making (Cavenagh & Newton, 1970; Dolan, et al., 1999; Peay, 1981; Richardson & Machin, 2000b; Swain, 2000).

There is, however, some positive evidence emerging from the literature regarding several tribunals' efforts to enhance therapeutic relationships. The most compelling evidence for this claim is provided in the context of tribunals in Canada and New Zealand (Diesfeld & McKenna, 2006; Diesfeld & McKenna, 2007; Yip, 2004). Overreliance on the clinical domain has been associated with tribunals considering factors beyond their jurisdiction, such as taking an interventionist approach regarding clinical decisions (e.g., Diesfeld & McKenna, 2006; Diesfeld & McKenna, 2007; Ferencz, 2003; Ferencz & McGuire, 2000; Hepworth, 1983; Richardson & Machin, 2000b). This could be interpreted as an effort by tribunals to further enhance therapeutic outcomes.

The findings of empirical studies have important practical implications for improvement of the mental health tribunal system and suggest that applicants' and carers' perspectives are invaluable in planning any future reform. A clear recommendation revolved around making the process more inquisitorial and informal, paying close attention to the seating arrangement and the way questions are asked, how issues are discussed and the manner of address used by members (Carney, 2010). Giving more attention to specific training and support for all members and professionals was also suggested (Dibben, Wong, & Hunt, 2005), especially in order to aid in clarifying the behavioural bases of such criteria as 'dangerousness' and 'insight' for the panel members (Peay, 1981). Improving applicants' access to information, advocacy and

advice to allow them to best prepare for their review applications (Peay, 1981; Swain, 2000; Topp, et al., 2008; Yip, 2004); reflecting about the impact of decisions upon service users within written decisions (Diesfeld & McKenna, 2005) and involving carers more in the decision-making process were among the recommendations aimed at addressing applicants dissatisfaction with tribunals (Diesfeld & McKenna, 2006). The need to improve the quality of evidence was also cited as an area for improvement, particularly in regard to helping clinicians prepare reports through the introduction of guidelines and check-lists (Dibben, et al., 2005; Egleston & Hunter, 2002 ; Naeem, Gupta, Rutherford, Gachen, & Roberts, 2007; O'Muirithe & Shankar, 2008). Finally, recommendations for allowing tribunals more diverse powers were discussed in some of the literature (e.g., Carney, 2010; Diesfeld & McKenna, 2007). Specifically, this involved requiring the detaining authority to guarantee adequate community based resources (Yip, 2004), encouraging treating staff to engage more openly with applicants and their families in deciding what treatments are appropriate, and making decisions about future treatment (Carney, 2010).

This literature review identified similar shortfalls and areas for improvement in current tribunals across various jurisdictions. It is important for policy makers and practitioners to become more aware of these issues in order to be able to achieve fair, just and improved therapeutic outcomes for vulnerable people, without compromising public safety.

5 Characteristics of the MHRT

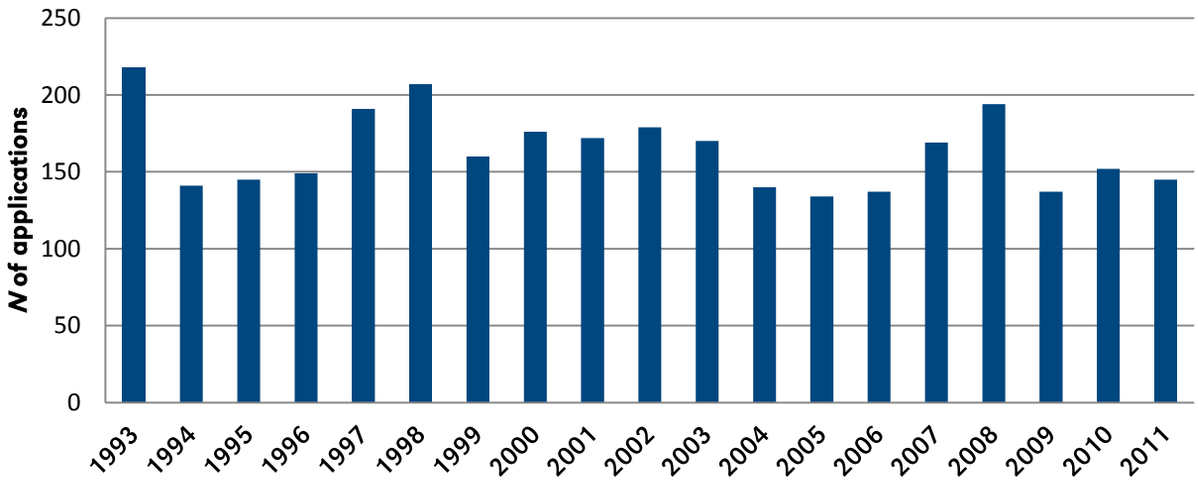
This section provides a descriptive analysis of statistics held by the MHRT from 1993 to 2011.[1]

5.1 MHRT application and hearing characteristics 1993-2011

5.1.1 Total number of applications

A total of 3117 applications were received by the MHRT between 1993 and 2011. Figure three illustrates the number of applications by year. It shows that the total number of applications lodged with the MHRT remained relatively stable over this period, with an average of 164 applications per year. There was a slight peak in applications during 1993, which is understandable given it was the first year the MHRT was in operation. There was also a moderate increase between 1997 and 1998 and then again in 2008.

Figure 3. Applications to the MHRT 1993-2011 (n=3117)



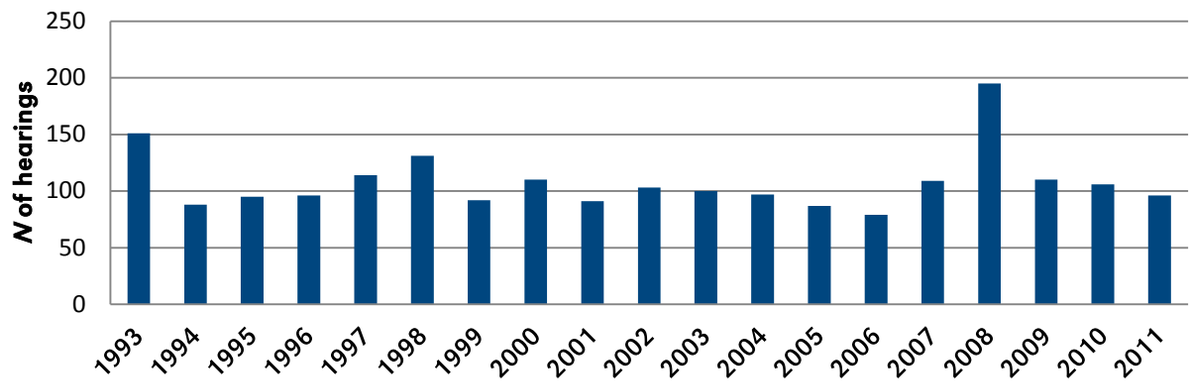
5.1.2 Total number of hearings

Figure 4 illustrates the number of applications that proceeded to a hearing between 1993 and 2011. Not all applications to the MHRT proceed to a hearing. In fact, 45% of applications were withdrawn within this period, giving a total 1642 hearings that actually took place between 1993 and 2011.

The MHRT database at times contained notes detailing the reasons for applications being withdrawn. These notes indicated that many applications were withdrawn by the applicant before the hearing was due to take place, in some cases on the day of the hearing. Why applicants withdraw their applications is largely unknown and there was a considerable amount of missing data within the MHRT database in this regard. In most cases where there was some information included in the MHRT database, the reason for withdrawal related to applicants having their legal status changed to 'informal' in the period between the applicant lodging their application and the hearing date being organised. In a few other cases, applications were deemed ineligible because the applicant was already informal when placing the application.

[1] Please note this analysis may differ from that which is reported in MHRT Annual Reports and the Director of Mental Health Annual Reports due to our methods of data cleaning and reorganisation of data variables.

Figure 4. MHRT hearings 1993-2011 (n=1642)



5.1.3 Applicant demographics

Figure 5 presents the demographic data of applicants who made applications and proceeded to a hearing between 1993 and 2011. The descriptive analysis of the data held in the MHRT database gives us a limited demographic picture of applicants. Information held by the MHRT database regarding demographics was often incomplete and our analysis does not take into account repeat applicants. This means that the demographic data may be skewed by including the same applicant's age and ethnicity more than once.

Most MHRT applications were received from males (n=2039, 65%) of New Zealand European ethnicity between the ages of 35 and 64 years. The mean age of applicants, including those applications which proceeded to a hearing, was 49 years. Although there was little missing data on gender, there was 50% of missing data in the other categories.

Figure 5. Demographic data for MHRT applications and hearings 1993-2011

	Applications (n=3117)		*Hearings (n=1642)*	
	N	%	*N*	%
Gender				
Female	873	28.01	417	25.40
Male	2039	65.42	1190	72.47
Missing data	205	6.58	35	2.13
Age				
21 <	14	0.45	9	0.55
22 – 34	214	6.87	148	9.01
35 – 44	449	14.40	308	18.76
45 – 54	508	16.30	346	21.07
55 – 64	328	10.52	230	14.01
65 >	232	7.44	168	10.23
Missing data	1372	44.02	433	26.36
Ethnicity				
NZ European	758	24.32	486	29.60
Maori	336	10.78	225	13.70
Pacific	70	2.25	48	2.92
Asian	31	0.99	24	1.46
Indian	4	0.13	3	0.18
Other	49	1.57	38	2.31
Missing data	1869	59.96	818	49.82

5.1.4 Legal status of applicants

Applicants were receiving their compulsory assessment and treatment as an inpatient (n=1089, 34.9%) or a patient in the community (n=883, 28%). Only a small minority had a forensic legal status of special or restricted patient (n=165, 5.2% in total). In a third of cases, however, the legal status was unknown according to the MHRT database (n=975, 31.2%).

For applicants whose application proceeded to a hearing, 21% (n=653) were inpatients and 17% (n=521) community patients. As with all applications, only a small minority had a forensic legal status (n=129, 4%) and in 11% of cases (n=339) the legal status was unknown.

5.1.5 Location of applicants

Figure 6 presents the applications and hearings by District Health Board (DHB) between 1993 and 2011. It shows that most applications and hearings were received by applicants within the Waitemata, Capital and Coast and Auckland DHBs. The lowest number of applications and hearings were received from applicants within the Wairarapa and South Canterbury DHBs.[2] This finding is understandable given these DHBs have limited inpatient services.

Figure 6. MHRT applications and hearings by DHB 1993-2011

	Applications (n=3117)		*Hearings (n=1642)*	
	N	%	N	%
Northland	46	1.48	23	1.40
Auckland	**348**	**11.16**	**167**	**10.17**
Waitemata	**589**	**18.90**	**310**	**18.88**
Counties-Manukau	237	7.60	136	8.28
Waikato	183	5.87	102	6.21
Bay of Plenty	36	1.15	22	1.34
Lakes	10	0.32	5	0.30
Tarawhiti	17	0.55	7	0.43
Hawkes Bay	29	0.93	12	0.73
Taranaki	78	2.50	32	1.95
Mid-central	128	4.11	79	4.81
Wanganui	130	4.17	71	4.32
Wairarapa	4	0.13	2	0.12
Capital and Coast	**529**	**16.97**	**321**	**19.55**
Hutt Valley	12	0.38	6	0.37
Nelson-Marlborough	37	1.19	25	1.52
West Coast	14	0.45	9	0.55
Canterbury	246	7.89	151	9.20
South Canterbury	4	0.13	2	0.12
Southern	222	7.12	137	8.34
Missing data	218	6.99	23	1.40
Total	**3117**	**100**	**1642**	**100**

[2] Please note that to complete this analysis, the research team carefully adapted the existing MHRT database by assigning a DHB region to each clinic/service specified. The assignment of a DHB was independently checked by two members of the research team to ensure accuracy. Nonetheless, the team expects there may be some errors due to the way in which data was originally entered into the MHRT database.

5.2 MHRT outcomes 1993-2011

5.2.1 Outcomes of hearings

At figure 7 indicates, most hearings result in applicants not being released (n=1392, 85%). There were 112 (7%) applicants that were released and 29 (2%) applicants given a recommendation for change in legal status.

Figure 7. MHRT hearings outcomes 1993-2011

	N	%
Released	112	6.82
Not released	1392	84.77
Recommendation for change in legal status	29	1.77
Missing data	109	6.64
Total	1642	100

5.2.2 Characteristics of those released or not released

Figure 8 illustrates that most applicants released were male (64%, n=71) and receiving their compulsory assessment and treatment either in an inpatient (33%, n=37) or community setting (46%, n=52). It was not possible to create further cross-tabulations given the missing data for most other categories were significant.

Figure 8. MHRT hearings outcomes 1993-2011 by gender and legal status

	Released		*Not released*	
	N	%	*N*	%
Gender				
Male	71	63.39	1030	74.31
Female	41	36.60	356	25.67
Legal status				
Inpatient	37	33.03	596	57.98
Community	52	46.42	454	43.32

5.2.3 Close-up of outcomes for inpatients and community patients only

Figure 9 presents the characteristics of inpatient and community applicants who were released between 1993 and 2011 (n=89). Over half of applicants released following a MHRT hearing were male and between the ages of 35 and 64 years of age. Interestingly, there were more successful applicants from Southern, Capital and Coast, Waikato and Auckland DHB.

Figure 9. Characteristics of inpatient and community applicants released 1993-2011

		Released (n=89)	
		N	%
Gender			
	Male	57	64.04
	Female	32	35.96
Age			
	1 <	2	2.25
	22 – 34	10	11.24
	35 – 44	18	20.23

	45 – 54	18	20.23
	55 – 64	19	21.35
	65 >	7	7.97
	Missing data	15	16.95
Location			
	Northland	2	2.25
	Auckland	**9**	**10.11**
	Waitemata	8	8.99
	Counties-Manukau	4	4.49
	Waikato	**9**	**10.11**
	Bay of Plenty	1	1.12
	Lakes	0	0
	Tarawhiti	1	1.12
	Hawkes Bay	0	0
	Taranaki	2	2.25
	Mid-central	6	6.74
	Wanganui	6	6.74
	Wairarapa	0	0
	Capital and Coast	**12**	**13.48**
	Hutt Valley	1	1.12
	Nelson-Marlborough	2	2.25
	West Coast	1	1.12
	Canterbury	7	7.87
	South Canterbury	0	0
	Southern	**18**	**20.23**

5.3 Summary

This section provided a descriptive analysis of statistics held by the MHRT from 1993 to 2011. Overall the analysis indicated most applicants do not receive a change in legal status following review from the MHRT. Only 7% of applicants reviewed were released and 2% were given a recommendation for change in forensic status. When the sample was reduced to include applicants receiving their compulsory treatment in an inpatient or community mental health setting (i.e. excluding forensic patients) cross-tabulations revealed males, between 35 and 64 years of age located in the Southern, Capital and Coast, Waikato and Auckland DHBs were more likely to be released.

There were no trends identified in the total number of applications received by the MHRT between 1993 and 2011. The number of applications withdrawn, however, was and continues to be high (at 45%) and reasons for this are largely unknown. Additionally, at times there was missing information regarding the demographics of applicants, their legal status and location. Further consideration and support for robust collection of this data would be useful in conducting further analyses.

The analysis indicates that there were a similar number of applications received from inpatient and community patients. Thirty-five per cent of applications were received from inpatients and 28% community patients. Current statistics indicate, however, that most patients receive their compulsory treatment in the community (see Director of Mental Health Annual Reports), indicating the legal status of applicants does not reflect this wider population. Although it is

unclear what the reasons for this might be, a recent study on the role of district inspectors suggested these legal professionals struggle to meet the demands of visitations with people who are subject to community treatment orders (Thom, Prebble, Black, & Diesfeld, 2013). This may mean that people under community treatment orders are not as routinely informed about their right to apply to the MHRT in comparison with inpatients detained under the Act who are easily accessible to district inspectors. With rates of compulsory treatment in the community rising (O'Brien, 2013), ensuring the legal rights available to people under compulsory treatment orders are well known is an important issue that need addressing.

6 The MHRT in practice

Section six summarises the key findings of the qualitative arm of this project. Throughout this section, excerpts from the interviews, written decisions and recordings of MHRT hearings are used to illustrate points we are making. To differentiate qualitative data, verbatim interview extracts have been formatted using *italics in blue*, observational data is contained with highlighted blue boxes, and written decisions using normal blue font. Due to the large amount of data collected for this aspect of the project, this section specifically considers practices relating to hearings under section 79 of the Act only.

6.1 Backgrounds, training, and roles of members

6.1.1 Becoming a member

> *I love working on the tribunal. It's great. It's enriching. It's intellectually challenging. It's stimulating. There's scope for humanity. I think it has been one of the highlights of my career, definitely (Tribunal member #10).*

Most of the members and deputy members (hereafter 'members') interviewed for this study had been in the role for over three years, with six being in the role for longer than nine years. Only three members had appointments for less than three years at the time of the interview. Two members had been in the role since the current Act was implemented in 1992.

The members had a diverse range of experience that led to them having an interest in applying for an appointment to the MHRT. Generally most members indicated that they had an interest or work experience in mental health law prior to their appointment to the MHRT. Although a few members had been approached to apply, most applied after observing the advertisement for the position.

Legal members tended to have prior mental health law experience, including undertaking the statutory role of district inspector, and reported that their previous experience made the transition to working with the MHRT easier: "*I suppose that's part of why I became a member of the tribunal. I've had a very long interest in mental health consumers and their rights and interests..." (Tribunal member #9).* The legal members continued to manage private legal practice alongside their appointment in a variety of areas, including: criminal law, family law, civil litigation, or dealing with vulnerable clients subject to the Protection of Person and Property Rights Act.

The psychiatrist members reported having had long-term experience working with people detained under the Act. Many had also held statutory roles under the Act as responsible clinicians or Directors of Area Mental Health Services (DAMHS). The psychiatric members also had varying workloads outside of their MHRT work, which spanned clinical, management, administrative and medico-legal responsibilities. The psychiatric members generally saw their appointment as an opportunity to extend their skills and observe how different services operated outside their clinical service:

> *I've been a psychiatrist for lots of years. I've had a lot to do with Mental Health Act proceedings over the years. I've seen the Tribunal at work. It seemed like an interesting thing to be a part of... it's, so far interesting and enjoyable. It's very interesting to see how things are done in other parts of the country as much as anything else, too actually (Tribunal member #12).*

Two out of the four community members reported they were approached to apply for an appointment to the MHRT, while the others had previous work experience that led them to have the requisite knowledge about the MHRT to make an application. Collectively, the depth and breadth of experience amongst the community members was notable. Those interviewed had experience working in a variety of fields including education, journalism, media, community work, health sector or had held advocacy or lay representative roles across a number of government boards or departments.

6.1.2 Induction and training

Rather than formal training, members received a comprehensive induction process on commencement of the role. The induction process included an opportunity to observe one or two hearings, as well as being given a book of readings that included MHRT written decisions, court decisions relevant to the MHRT, and academic materials on topical issues. Most members viewed the induction process as sufficient given their prior experience.

On-going support is provided by way of two plenary sessions held annually. The plenary sessions provide an opportunity to learn from recent MHRT cases, relevant research and legislative changes of interest. They also provide an opportunity for collegiality.

> *So there is a sense of peer review, there's an education sense to it, keeping up to date with, you know what the interpretations are around the legislation. We've got the plenary days and there's normally some good learning to be had out of that (Tribunal member #6).*

The plenary sessions were described by one member as offering opportunities to consider a variety of perspectives on mental health brought about by the mingling of diverse backgrounds of the members. This included alternative cultural and/or consumer-led understanding of mental illness.

> *I would say that when considering our cases we're often mindful, I'm mindful and I'm sure other tribunal members are mindful of whether our perspectives are realistic and appropriate. We are aware that one can occupy different worlds. We meet roughly twice a year as a tribunal collectively and we have these quite free-ranging discussions where these issues and topics get brought out and bandied about (Tribunal member #1).*

Some members use other means of keeping themselves up-to-date with current legal issues in mental health including subscribing and reading journal articles of the *Australia and New Zealand Association for Psychiatry Psychology and Law*, informal sharing of other journal articles, and attendance at relevant conferences.

6.1.3 Defining roles

Members were asked to describe the contribution of each role – community, legal and psychiatric – that comprises the tribunal. This often led to discussions around the value that each member brings to proceedings and there was a sense that each member contributed equally. One member articulated such equality in valuable contribution in the following way:

> *Well, the three [members] work on an equal footing. So when you're in a hearing, we all have input to the decision. So we don't have rigidly defined roles. We work as a threesome, and we can each take any part in the hearing. We all bring our own backgrounds and skills (Tribunal member #13).*

The composition of the panel was conceptualised as providing a 'balance' to MHRT processes and decision-making:

[Lawyers] are expected of course to have their general legal knowledge and psychiatrists are of course expected to have their psychiatric knowledge, so one wouldn't expect there to be a need for training of lawyers about the law, or psychiatrists about psychiatry. There are of course the community members of the tribunal, and they bring their general knowledge and interests, and different perspectives to the work of the tribunal, so it's a nice balance (Tribunal member #1).

This quote suggests the addition of the community members ensures a more generalised perspective that complements the specialised psychiatric and legal knowledge of the other members.

Legal members

The legal member generally presides over hearings. In some cases, the hearing is not led by the legal member; this variance is described further in section 6.3.

The legal members reported that their specific duty is to ensure there is a legal basis to every decision of the MHRT. This duty involves careful consideration as to whether the deprivation of the applicant's liberty is justified given regard to relevant laws:

The lawyer's view which is: has the statutory basis for depriving this person of their liberty been met? And you have to start with the Bill of Rights, which is that no person will be arbitrarily detained. And that no person shall receive medical attention against their will (Tribunal member #7).

How the hearing is conducted was also important to legal members. A core aspect of their role is to ensure the correct legal processes are followed in the pursuit of natural justice:

The presiding member, the member who presides, if you like, who leads each hearing is the lawyer. And that's entirely appropriate because it's a legal process, and lawyers are good at process, how to run hearings, if you like. And, because lawyers have experience of court processes and so on, and such issues as the fulfilment of the requirements of natural justice, come naturally to, and easily to lawyers (Tribunal member #1).

Fair processes that involve equal consideration of evidence are an important aspect of their role in ensuring natural justice:

I see the lawyer member as having a primary responsibility first for the fairness of the process and so an aliveness to, an alertness to all of the evidential issues is really important. Making sure [for example] that the applicant and their lawyer has seen all the evidence (Tribunal member #9).

Most members acknowledged that the legal members were best placed to ensure the correct legal processes were followed and the quality of the evidence presented was acceptable.

Psychiatric members

The psychiatric members described various ways in which they contribute to the MHRT panel. In an advisory capacity, they reported assisting the legal and community members with understanding psychiatric diagnoses, prognosis and treatment options. Their specific expertise assists the panel to consider the likely outcomes for the applicant given their specific treatment pathway:

I might have particular knowledge about the way that a particular illness or mental condition may carry some sort of prognostic outcome, or it might be affected by certain

kinds of treatment considerations. So I may say something like, 'well the chances of this relapsing if that person stops the medication is at this kind of level' (Tribunal member #13).

They also described their important role in scrutinising the psychiatric evidence provided by the responsible clinician during the hearings. Given the specialist training psychiatrists receive, they also felt well placed to provide insights into the best approach for questioning applicants during hearings:

I think there's some assistance to be made sometimes just in the running of the interviews, and you know, how people are approached. How people are questioned if you've got, you know, sometimes you might have someone very thought disorganised or someone very paranoid, very guarded, who doesn't want to say very much at all. You certainly might, you know, use your training, I guess, in the way that you talk to them, but also maybe there's some discussion amongst the group about what is the best way of approaching this particular patient – how are we going to communicate most effectively? How are we going to make sure they get the best opportunity of being heard? (Tribunal member #6).

The legal and community members also reported how instrumental the expertise of the psychiatric member is to clarifying diagnostic and treatment issues related to mental illness.

...they can very usefully make sure we have clarity on clinical issues and they can ask a responsible clinician in a very informed way, 'why is this person on this dosage of medication? That is outside of best clinical guidelines. Tell me why this is happening?' And those exchanges happen, that's kind of crucial. It's not really relevant to fit to be released but it's highly relevant to understanding or some extent challenging what is happening in the treatment regime (Tribunal member #9).

As this quote suggests, some of the members saw an important part of the psychiatric member's role as assisting in challenging the evidence presented by responsible clinicians.

Community tribunal member

The community members perceived their role as providing perspectives *"outside of psychiatry and law"*, allowing the applicant to be viewed *"from a humane perspective...as a person, he's from our community and he needs to be heard" (Tribunal member #4)*. A particular theme that ran through the interviews with the community members was conceptualising their role as pushing for a holistic picture of the applicant:

I try to really question the medical model if you like, because there are other ways of doing things. And there's a real holistic way of looking at that person and how that person is functioning (Tribunal member #14).

I suppose I think that the role is to see the person in the whole of their life, in their context, and to...see people as people (Tribunal member #8).

Other members who were interviewed reiterated that community members provided a perspective anchored in their divergent life experiences, rather than the disciplines of law and psychiatry, and that this create a good balance for the panel (Tribunal members #11, #12, #13).

You know the whole context of this mental health law is, if you like, community and how the mental health system fits into the community and relates to the individual community members, and issues of rights, and expectations and so on...Community members bring

their own perspective to that. So often the applicants might be able to be a little more relaxed with community members and are appreciative of community members because a) they are not terrible lawyers, and (b) they are not terrible psychiatrists – a more friendly face (Tribunal member #1).

The role was also seen as making the hearings more accessible to applicants and their whānau by reducing the amount of technical medico-legal language used (Tribunal member #2), a sentiment shared by community members:

I see my role as helping to put people as ease and couching things in terms that people use rather than clinicians or lawyers use (Tribunal member #8).

Many of the legal and psychiatric members also described how the presence of the community member can put applicants at ease, creating a more relaxed environment (Tribunal member #1). They were described by other members as being a 'friendly face' to applicants who, in some cases, had an ability to elicit great detail of the applicants' needs during a hearing:

The way they [community members] sometimes will question the patient, and talk to them at the right level...bring[s] information out about what the patient really wants, or really thinks, and it's not infrequent that you'll see a kind of, you know a raising of the eyebrows, almost like a dawning realisation on the team members in the room that they're actually, you suddenly realise they're hearing this for the first time. They've known the patient for a long time (Tribunal member #6).

Another community member stated they focused on the supports in place for applicants, directing their attention not only what is said but also non-verbal cues, such as facial or body language:

I'm always interested in what the family have to say.... You just take a look around and somebody will nod or shake their head and say that's not true, or that is true. And it's quite interesting, so I see it as my job to keep scanning the faces... It's very easy to write in a report this person has family support, [but] if you get to speak to them, [they say] we support him, but we can't have him come and live with us because, you know, we've got three little kids (Tribunal member #2)

There were, however, some criticisms of the community member role. A small minority of the legal and psychiatric members argued that the community member role as it stands was unnecessary for two reasons. Firstly, it was argued that the community member does not possess a monopoly over effective communication with applicants – the psychiatric and legal members are capable of gaining similar insights from applicants as lay members. Secondly, all the members are part of a community and as such have a wide range of other interests, skills and experiences outside of the professional discipline.

...having community members kind of ignores the fact that lawyers and psychiatrists are members of the community as well and we can bring most of what the community members bring to it. So why not have some consumers as community members? (Tribunal member #9)

During other interviews, the research team questioned the members on the option of having a consumer perspective on the panel. There was some support for this option, however, the topic was not considered in enough depth during the research process to suggest consumer representation on the panel as a strong recommendation to take forward.

6.2 Preparing for hearings

Following receipt of an application for review, a number of steps are taken to progress to a hearing. The legal firm who administer the hearings – D'Ath Partners – initiate the beginnings of organising the timings of hearings each month by matching members to hearings based on their availability. They also liaise with appropriate staff within mental health services to confirm a date and venue for each hearing.

Prior to all hearings a telephone conference takes place to gather preliminary information and confirm various matters with the applicant's lawyer and responsible clinician. The legal member who will be presiding over the hearing conducts the telephone conference which takes on average 10 minutes to complete. The aim of the telephone conference is to ensure scheduled hearings are reaffirmed, dates confirmed and details about the application are secured (e.g. demographics and legal status of applicant). Discussions also ensure that all information is prepared and provided by the responsible clinician and mental health service in a timely manner for the panel, applicant and his or her lawyer. Exactly what matters will be challenged by the applicant during the hearing are also canvassed:

> *Well the first thing you want to know is when it's actually going to happen. And then, yes, what sort of issues and who is likely to be there. I have a set questionnaire. I just roll through [the questionnaire]. I want to know from the lawyer whether both limbs are under challenge or just one limb... (Tribunal member #7).*

In many cases, the same responsible clinician and lawyer may be involved in more than one hearing a month, so the legal convener can efficiently conduct two or more pre-trial conversations in one conference call. The legal member may also take the opportunity to ask about the suitability of conducting the hearing via video conferencing.

There was variance in the way in which the information discussed in the pre-hearing telephone conference was relayed back to the other panel members. At times, legal members did not contact the psychiatric and community members, while others corresponded by email as to the details of the pre-trial conference.

> *Some lawyers have been very good and they will actually contact you, usually via e-mail. Occasionally they'll actually ring you and they'll say look we've just had the teleconference and this is what the information is, this is what the view is, it is going ahead, you know, others don't (Tribunal member #6).*

It appeared the psychiatric and community members appreciated having this information relayed.

All members then discussed receiving a package of materials relevant to the upcoming hearing. This package always included the responsible clinician's current reports and sometimes also included previous clinical reports and MHRT written decisions. The members reported receiving this package anywhere from a week to a day before a hearing.

On receiving the package, members read the materials thoroughly, at least once or if not twice, and took extensive notes in the margins, highlighting areas in the materials where they wanted further clarification. A legal member, for example, reported three things he looked for: firstly, the evidence the clinician provides in his or her determination of whether the applicant is/is not fit to be released; secondly, what information is missing; and thirdly, the questions that will need to be asked of different people during the hearing (Tribunal member #9). Overall, the

documentation generally enabled members to form a *"picture or a feel for the applicant, what they might be like" (Tribunal member #1).*

There were some difficulties reported by members in terms of accessing the right information on time. Some of the psychiatric members discussed the difficulty in receiving packages without clinical reports. Although the clinical reports could be viewed before the hearing takes place, there was often not enough time for a thorough investigation. Variance in the records and storage systems between DHBs was noted as being problematic for obtaining detailed information around the treatment and care provided to an applicant. This was particularly problematic where the applicant was a long-term service user and/or where they had moved from one region to another. There was also a variance in information provided. One member reported problems in receiving 'huge amounts' of old reports and previous MHRT decisions while in other cases only receiving only a brief report.

6.3 Opening a hearing

The legal member usually convenes the hearing. Members suggested each legal member conducts hearings differently but generally a hearing begins with a warm welcome, introductions and an outline of the purpose of the proceedings.[3] At this point, the breadth of authority of the MHRT was explained:

> *This Tribunal has a very limited jurisdiction, limited legal power. We can decide either that you should remain on that order and be subject to its conditions, or that you're fit to be released. We don't have a jurisdiction to interfere in treatment arrangements or your living arrangements, although we may have some interest in some of those things (Tribunal member #9).*

Finally, the opening of a hearing usually involved a detail of how the hearing would progress (see box one).

Box one. Opening a hearing, Hearing #8

Legal member	First your lawyer will outline what your case is, or has the opportunity to do that. Then we will hear from you – that's an opportunity for you to tell us what you think is important in the light of the decision we can make and also we will each ask you some questions. Then we will hear from your responsible clinician and from your nurse. For each of them, we will ask them some questions and your lawyer will have the opportunity to question them on your behalf. Then we have what lawyers call final submissions and then we either make a decision today or we give you an indication that it's going to take us however long.

[3] Just prior to the commencement of the hearing, the psychiatric member conducts a pre-hearing examination of the applicant. The psychiatric members interviewed reported that during this examination as brief (i.e. 5 minutes) and focused on checking the applicant's mental state and to make sure he or she is fit enough to go through the MHRT process. The process is also explained to the applicant at this point, to make sure what is likely to happen once they enter the room of the hearing is understood.

A deviation from the general process was described by some members, whereby a community or psychiatric member opens the hearing. This might occur in hearings where the panel members attempt to meet the cultural needs of applicants by allowing the member of the same ethnicity as the applicant to preside. This deviation in practice was not witnessed during our observations and was not evident any of the written decisions. Members also reported that the needs of Māori, Pacific, Iraqi and Chinese applicants had been catered for in past hearings by co-opting an extra member to represent the cultural and linguistic needs of the applicant. The Annual Report for the MHRT suggests co-opted members join the panel on average one to two times per year. Members interviewed were also open to the incorporating an applicant's religious beliefs if this made him or her more comfortable with the process. For example, members discussed hearings where the applicants wished to incorporate Catholic or Buddhist support persons and karakia or prayer into the hearing. Where an applicant spoke a different language, the services of an interpreter had also been sought.

6.4 The applicant's evidence

6.4.1 Opening submissions

The applicant's lawyer is invited to make their opening submission. During the interviews, members described how opening submissions may include the applicant's instructions and an outline of their specific challenge to the first or second limbs of the Act. The observation data provided 'in action' examples of opening submissions. Box two illustrates a common set of arguments put forth to the MHRT during an opening submission. It includes a lawyer's explanation that their client does not agree they are mentally disordered within the meaning of the Act; that the origin of the client's distress was not something that can be described as an abnormal state of mind; and that the applicant wishes to be released from treatment provided by mental health services.

Box two. Opening submission, Hearing #3

Sandy [applicant] seeks release from compulsory status on the basis that she's not mentally disordered. She doesn't accept what Dr Smith [responsible clinician] describes as an established diagnosis of schizophrenia. But legally she doesn't accept she has an abnormal state of mind, she doesn't accept the way it might be characterised and she doesn't; she wouldn't accept that she meets the severity criteria for mental disorder... Just finally, Sandy certainly doesn't accept she has any need for medication, and wouldn't take medication unless she was compelled to [despite an] improvement to her mental state since the IMI medication was administered. Now she doesn't accept there's been any change, she puts all of her history down to addiction issues that she has with alcohol and drugs and sees her future being dependent on abstaining from drugs or alcohol, and her chief support in that area would be her continued attendance at AA...

In four of the 11 hearings observed by the research team the applicant's lawyer argued that their client did not accept that they had a mental disorder either because he or she had been misdiagnosed, did not meet the severity criteria for this legal definition and/or did not pose a threat to themselves or others (Cf Hearings #3, #9, #6, #7).

During the observations, lawyers provided reasoned arguments to the panel that helped explain applicants' past incidents of problematic behaviour, such as *"being run down and stressed"* coinciding with hospital admissions. During the interviews, members confirmed these observations explaining that an applicant's lawyer may describe some details about the applicant's past behaviour and treatment and the circumstances around particular risky incidences.

It is important to note that not all hearings follow this line of argument. An applicant may agree to some extent with the diagnosis they have been given by their responsible clinician and appear compliant with their treatment plan. The applicant's disagreement is with their compulsory legal status; they believe they can remain compliant without being under the Act. In these cases, lawyers tended to argue for a general lack of evidence supporting limb two of the definition of mental disorder, or in other words, the applicant's risk to self or others, or inability for self-care. This was described by members as the most common argument put forth in opening submissions: *"The lawyers very commonly don't challenge the first limb. They look at the second limb and so they make judgements around management of risk"* (Tribunal member #10).

The written decisions provided many illustrations of clear opening submissions by lawyers that drew attention to the criteria of the second limb of the mental disorder definition not being met, at times supplemented with written submissions and case law to strengthen the applicant's position:

> With regard to self-care, Ms Smith [lawyer] made reference to Re C 28/8/00/Judge Thornburn, DC Auckland CAT132/99. She submitted that it was helpful to ask whether the Applicant is functioning properly in his "social realm" and then ask whether that standard of self-care would be acceptable as a minimum standard considered from an ordinary person's perspective (Written decision #33).

> Ms Franks [lawyer] provided written submissions which she introduced and spoke to…the submission referred to authoritative case law which the Tribunal accepts as such, principally the Court of Appeal decision in Re: H, and submitted the Tribunal should take the least restrictive approach possible (Written decision #25).

Evidence in support of the overall argument being put to the MHRT by the applicant is then given by most lawyers in the remainder of their opening submission. The level of progress the applicant has made in their lives, such as improving their ability to socialise with others and attempts at (re)strengthening of on-going support systems, were also an issue the members had observed lawyers covered in their opening submissions (Tribunal member #2). During the observations of hearings, topics addressed included: coverage of an applicant's lack of hospital admissions over eight years (Hearing #4); independent living and healthy relationships with neighbours (Hearing #11); good integration within a residential accommodation, caring for oneself and seeing family (Hearing #8).

Where it was accepted by the applicant that they had a mental illness that could be understood as an abnormal state of mind, lawyers tended to highlight positive aspects of their client's compliance with treatment plans and methods for managing their own mental health. In one case the research team observed, for example, a lawyer argued that their client would continue to take their medication voluntarily and desired to be treated as a 'responsible adult', taking responsibility for this own health like most other people suffering from a chronic condition (Hearing #4). In another opening submission, a lawyer stressed that their client would continue to meet voluntarily with their key worker and responsible clinician as required (Hearing #8).

Opening submissions may also cover concerns outside the scope of the MHRT. The interviews, observations and analysis of written decisions, suggest a large majority of the arguments put forward by applicants' lawyers contained concerns over their client's current treatment plans, rather than legal status per se. As member #6 states:

> *It's often not about legal status; it's about all sorts of other things. It's about whether they should be allowed to be in the community under compulsion, rather than on the ward. Whether they should get new meds, or sometimes they want to change a doctor or something because they have a poor relationship (Tribunal member #6).*

This tribunal member went on to describe the link between poor therapeutic relationships being a critical factor in the applicant's reasoning for lodging their applications.

> *There seems to be a greater preponderance of patients that come to the tribunals with their responsible clinicians when there is clearly a very poor relationship...and I wonder about that being something that influences the patient's decision about choosing to bring a case to the tribunal (Tribunal member #6).*

The research team, for example, observed complaints regarding the intolerable side effects of certain medications (difficulty in sleeping, swallowing and heightened anxiety) (Cf. Hearing #9); preferences to take their medication orally rather than via injection (Cf. Hearing #4); and perceptions of problematic clinical care they were receiving from a specific mental health service (Cf. Hearing #8) In one case the lawyer took the opportunity to present their client's desire to seek alternative accommodation (Hearing #3, #8, #9). The following example from a written decision illustrates that the core concern of the applicant was the continued use of a particular medication regime, with a tenuous link being made by the lawyer between this concern and being released from compulsory treatment:

> Mr Smith [lawyer] said the reason the Applicant has applied for release from compulsory status as this stage is that he does not wish to take clozapine. He considers that clozapine interferes with his sleep and causes him to feel anxious and unsafe. He does not consider clozapine to be of any benefit whatsoever (Written decision #42).

Although, the MHRT has no authoritative powers to address treatment plans, the panel have delivered decisions with an underlying message that progress is required in an applicant's case. The covert interventionist approach of the MHRT is described further in section 6.8.

6.4.2 Questioning the applicant

Once the opening submission is complete, the legal member then invites the applicant to speak. Giving the applicant an opportunity to speak to the panel first was viewed as important: *"The applicant is given a voice, it is about them and we should really hear from them first. And secondly, by talking to the applicant we get some sense of the applicant" (Tribunal member #1).* There were variances in how this applicant's chose to give their evidence and tell their story.

The applicants' lawyers may guide the delivery of the applicant's evidence by asking *"a series of questions which enable the person to structure what they need to say. They lead their evidence. And that is a really useful contribution because it means that the lawyer prompts them" (Tribunal member #9).* Such questions may cover current living situations, daily activities and routines, experience of current medication, and relationships with support persons. During one observation of a hearing, an applicant had carefully prepared a statement to read to the panel. This statement provided the applicant time to detail with specificity their account of events that ranged across a 50 year span of receiving psychiatric treatment, medication and painful side effects, verbal abuse from health professionals and a long trail of destructive behaviours related

to alcoholism resulting in other threatening behaviours. The applicant then described the changes they have gone through connecting with God and finding happiness, while expressing their deep desire to be discharged and to have the opportunity to be treated like every other human being (Hearing #7). In a few hearings, it was apparent that applicants found it difficult to speak freely and preferred moving straight into the next process of being questioned by the panel.

The members interviewed explained that their opening questions to the applicant aimed to put them at ease. Members described how they often begin with opening questions that included enquiries about the applicant's background and, if relevant, acknowledgment of meeting the applicant during a previous hearing:

> *I see my role as putting them at ease, getting them talking, getting people starting to talk, feeling like they can talk in that setting because people are scared. It's very important for them and a lot hangs on it for people... it's actually about setting the climate of the Hearing and making the person realise that we are there to listen (Tribunal member #8).*

The applicant is generally questioned by each member in turn. The observational data generated information on the range of questions members canvas. All of the members asked in varying ways similar questions of the applicant including: their journey so far through mental health services (treatment and medication; reasons for past behaviour), patterns of disengagement from mental health services, the involvement of physical health needs, possible effects of alcohol and drug use and who their supports were (e.g. family, friends, services, residential accommodation staff). A series of questions were usually then asked to gain insights into the applicants' perception of the risk they may pose to themselves or others when unwell and what their future plans entailed.

Members explained that there can be flexibility with who asks what questions of the applicant, as one psychiatric member stated:

> *...there can be some difficulty in dividing up, you know, who asks – do I only ask the psychiatric questions? Or can I ask some questions about the person's social circumstances that I am interested in? But then am I stealing the law person's thunder and vice versa? The lawyer will often ask questions of the responsible clinician about mental states and all sorts of things you had down to ask as well. It doesn't really matter who asks it...So I find that generally it mixes and matches (Tribunal member #6).*

During the observations, however, the research team noted similarities between the questions asked by the different member groupings. As box three illustrates, the psychiatric members focused on questions about the applicant's treatment or explanation for their past patterns of behaviour.

Box three. Questioning the applicant, hearing #3

Psychiatric member: Looking at the information I've got, it appears, it looks like that you get better with some treatment as provided in hospital and then when you don't get the treatment in the community, your life drifts again, and a crisis situation develops, and you end up back in hospital again.

Applicant: I had to stop drinking and take responsibility, or try to take responsibility for my actions because I realise that I can't lean on the hospital system, because, because of my dependency problems...

The community member tended to make general inquires about the applicant's social circumstances, for example: how they filled their time, how relationship with others in their lives were going, or what their future plans included. Box four highlights the line of questioning community members often took during hearings.

Box four: Questioning the applicant, hearing #3

Community member: Okay, you said you'd quite like to go to work and that you applied for couple of things. Do you feel that you would like some training to help you do something, or what are your hobbies or your interests?

Applicant: Training would be good, I feel like if I could get a job tomorrow I would take it. Training would be interesting, good, I'd like an apprenticeship.

In some cases the legal members refrained from asking questions until after the other members have completed their questioning and focused on generating information not covered previously. During an interview, a legal member provided their reasoning behind this approach:

> *And so while I certainly ask some questions, I prefer my colleagues to do their questioning first so that I can listen to the evidence.... And because we don't record the hearings, I usually write extensive notes and because the way the tribunal's organised, the lawyer member usually does the first draft of the decisions (Tribunal member #9).*

This legal member reported the importance of detailing the evidence provided during the hearing in preparation for their drafting of the written decision.

It was important to the members interviewed that they created an environment throughout the questioning that ensured the applicant felt they had been heard. For many members, this meant continually checking their body language and general presentation to all parties at the hearing:

> *So that they're not sitting there very formally and we're sitting there slurping drinks, you know we sit, you know people tend to just make an effort to be, you know upright, and alert, and look interested, and listen. And most of us will take notes, to varying degrees, some people take loads of notes, other people don't take too much. So it's the whole thing about just how you present yourselves, how you deliver things (Tribunal member #6).*

Although previous applicants were not interviewed for this study, some of the data collected does point to the fact that some applicants do feel listened to during hearings, regardless of the negative outcomes. Box five provides one illustration of such a positive experience.

Box five: Example of feeling listened to, hearing #11

Legal member: Is there anything else you want to say?

Applicant: You've been good, you've listened to me and you haven't appeared to have squared me away yet.

Once the members completed their questions for the applicant, the legal members were inclined to thank the applicant and reiterate the next step in the hearing process. The applicant may also be reminded not to interject whilst the MHRT hears from the other witnesses and that they will be given an opportunity to speak again later in the process.

6.5 Questioning clinicians, whānau and friends

6.5.1 Evidence from the responsible clinician

The responsible clinician is invited to speak to their report and answer any questions from the panel members and the applicant's lawyer.

Generally speaking, the psychiatric member was reported by members interviewed as leading the questioning of the responsible clinicians. The observations of hearings illuminated that the questioning of responsible clinicians focused on a number of areas, including: clinician's knowledge of the applicant's background; co-morbidity issues; diagnosis; current mental health; current treatment plan; medication; risks factors; support structures and future plans. Additional questions covered factors such as length of time in treatment, past alcohol and drug use and behaviours, and compliance use with medication. The following excerpt from a responsible clinician's report included in a written decision, illustrate how these issues are generally canvassed:

> At my last review of him [the applicant] he was bright and cheerful. He had engaged in a number of activities including AA sessions and playing tennis regularly. He spoke at that time with some insight into his illness and the need for medication. However I must say that this was the first time that I had heard this from him. Prior to that he had always minimised his illness, shown very little understanding of it and absolutely no understanding of the importance of medication and remaining well. In fact a number of my past letters over the years indicate that he has felt that he doesn't need the medication and doesn't intend to go on taking it. Naturally this is of grave concern given that his suicide risk escalates markedly when his mood drops. He has a number of the classical suicide risk markers, namely he is a male of middle age, who is relatively socially isolated and who suffers from a long term mental illness, depression, alcohol dependence and a parent who committed suicide (Written decision #21).

From the legal members' perspective it was crucial that the responsible clinician draw on all this evidence in their report and *"translate it to the definition of mental disorder" (Tribunal member #9).*

In carrying out their questioning, the members were cognisant of the complex nature of a 'patient-doctor' relationship within the context of compulsory treatment:

The relationship between the clinical team and the patient when the patient is under the mental health act is very complex because on the one hand you've got the very clear thing that the responsible clinician is making a decision that disagrees with what the patient wants…but often there is still a very therapeutic relationship. So you are sort of in this curious double relationship (Tribunal member #13).

Members highlighted the difficulties that arise in maintaining a positive patient-doctor relationship during the questioning of responsible clinicians. They reported being careful in their questioning to extract just enough information from the responsible clinician to assist in their decision-making without focusing on too many details that may cause distress to the applicant:

This patient has to relate to this doctor afterwards, so you extract the information, I guess, with a little more care and respect…I think you allow the responsible clinician to say things in a gentle way without making them spell out, you know, especially risk things. I mean you need enough information to make sure that criteria are met, but you don't need to make them kind of spell out every awful incident that will kind of upset the patient (Tribunal member #11).

In the hearings observed, for example, the responsible clinician often described the applicant in unflattering terms during their testimony (see first two examples in box six). This makes it difficult for the panel members to create an environment that attempts to enhance rather than damage on-going therapeutic relationships.

Box six: Responsible clinicans' descriptions of applicants

Responsible clinician: In my opinion Andrew's insight is poor. He doesn't accept the diagnosis of medical illness (Hearing # 11)

Responsible clinician: Tyler is easily frustrated and tends to focus on his immediate needs (Hearing #1)

Responsible clinician: He's a very sincere person, says things as they are. He's a very proud man (Hearing #2)

As the third example in box six indicates, some clinicians do take the opportunity during the hearing to praise the applicants. The written decisions confirmed this, with the following example showing a clinician validating an applicant's concerns about the side effects of his medication:

He understands the applicant's concerns about side effects of the medication, particularly weight gain and lethargy. Both of these he accepts as real concerns for the applicant (written decision #28).

Similarly, one member reported that 'good' clinicians have the ability to maintain a therapeutic relationship during hearings by referring to positive examples of the applicant's progress and situations where joint decisions had been made:

If you've got a hearing where you've got a very good responsible clinician who can give their evidence in a way that is actually maintaining a good relationship, you can get a quick feel for that. Good responsible clinicians will often give their evidence in a way that is addressed as much to the patient as it is to the Tribunal. It includes them and keeps

referring back to some of the joint decisions they might have made, and not just to the negative things (Tribunal member #13).

A community member similarly described hearings where the responsible clinician engaged the applicant in a discussion over the broad areas where they agree and disagree over treatment plans.

Some of the best hearings are where the responsible clinician and the applicant have a conversation...like the responsible clinician might say, 'Cassy I know that you and I agree on X,Y and Z but the points that we disagree on are A, B and C' and then they go on. And the point is that the applicant is included in the conversation and I think that is really important (Tribunal member #8).

This type of engagement contributes significantly to the MHRT aims of convening a hearing that is experienced by the applicant as fair, transparent and which does not damage therapeutic relationships.

At times, however, members described instances in which their abilities to conduct a hearing that enhances rather than damages therapeutic relationships is out of their control due to conflicts between applicants and clinical teams: *"If there is a poisonous relationship between the responsible clinician and the applicant, it can be very tricky to manage" (Tribunal member #10).*In such cases, members described how they actively attempt to mediate conflicts between applicants, their clinical team and family members if necessary in order to assist in the enhancement of therapeutic relations.

Sometimes we'll find within one of those hearings that the clinical team and the patient are absolutely at loggerheads...So we kind of then focus our energies a little bit onto sort of trying to almost mediate between the parties during the course of the hearing. That's not a deliberate part - it's not part of the tribunal structure (Tribunal member #13).

Another member added that care and caution was needed in applying a robust legal process without it producing a counterproductive adversarial process that damages the patient-clinician therapeutic relationship:

Yeah there is a clash there between the sort of therapeutic outcomes that a hearing can achieve and the necessity of the legal process. I mean the legal process has to be robust, and it has to be honest, and it has to deal with the issues... You can't fudge that. You don't have to do it in a rude or an offensive way or in a blunt way shall we say (Tribunal member #3).

Members' descriptions of 'mediating' during hearings reflect the therapeutic intentions embodied in the framework that drives the MHRT (see section 3). Ideally, this involves achieving an outcome that is the result of a careful balance of natural justice and practices that facilitate rather than damaging on-going therapeutic alliances.

The members stated, however, that in a minority of cases where they witnessed poor clinical practices mediation may not be possible. Panel members have been known to refer serious concerns about a responsible clinician to the relevant DAMHS. Two examples of such situations were given by psychiatric members. One case involved a responsible clinician lacking requisite knowledge of mental health law:

Clearly he'd been signed off as being allowed to act as a responsible clinician but didn't seem to have the adequate understanding of the law, and the definition, to actually fulfil

that role. So we wrote formally to the DAHMS to say we think there is a training issue here and you may want to consider whether this person should act as a responsible clinician (Tribunal member #6).

In another example, a psychiatric member described how questionable practice motivated their contact with the appropriate clinical director.

I have done that twice. One person was on a locked ward for six years and had never been given the medication clozapine and...it was something he wanted to do. I felt that was unethical because there was a 33% chance of it working, which was quite high really, and if it worked he could get out of the locked ward. So I rang the clinical director. Then last week's one [complaint] was around too much medication, dangerous levels of medication, and when we did the hearing we couldn't get any sense from the responsible clinician as to why he was on that sort of medication... (Tribunal member #10).

6.5.2 Evidence from other health professionals

The MHRT can hear from any number of witnesses, including other health professionals such as the applicant's key worker and/or community/in-patient nurse, psychologists and social workers. The members reported they often hear evidence from the key worker and rely greatly on this evidence because key workers generally spend more time with applicants than other professionals:

I like to hear what the key worker has to say because they are the person that sees the Applicant most frequently and, in fact often, the doctor's perspective is coloured by the information that they got from the key worker. So I'm always interested in what they are able to say (Tribunal member #8).

Obtaining this evidence was viewed by the members as critical to their decision making. In one case, a member reported that the MHRT members reserved their decision pending hearing evidence from the applicant's key worker. In this case, the panel was only able to question a responsible clinician who had met with the applicant once prior to the hearing and was unable to answer all the questions the panel had.

6.5.3 Evidence from whānau/family, friends and other support persons

The interviews with members revealed the perspectives of whānau/family and other support persons were extremely valuable. The evidence provided by support persons allows for information to be generated on the applicant in their social milieu, which was crucial for assessing risk and self-care issues.

At the same time, the members were cognisant that the applicant's support persons are often placed in a difficult position and that any questioning of them had to be dealt with sensitively. Several members reported family members to be in a precarious position of wanting to *"support the on-going use of the Mental Health Act but also want[ing] to support their family member" (Tribunal member #11)*. A community member described how she communicates with family to reduce the potential for on-going conflicts between the applicant and their support persons:

Instead of saying, "do you think this person needs to stay under the Act?" Maybe, "have you noticed any changes in your son/daughter over the last 6 months?" So it gives them a chance to avoid answering the question, while at the same time appearing to answer the question... The other way to get around that is to say to the applicant, "well mum's sitting there. If I ask her whether you should stay under the Act, what do you think she will say?" I think applicants are really honest and they might say "oh no, mum thinks I should stay under the Act." Often another way to get information is to watch other

people (or their reaction), there are other ways other than just the verbal (Tribunal member #8).

The written decisions suggest that in a minority of cases, support persons may present in opposition to the clinical team perspective, advocating strongly for the release of the applicant. One written decision noted such a situation and provided critical commentary on the future of the applicant's recovery given the nature of the support available him:

> The applicant's mother's challenge to clinical accounts is unreliable because her perception of past events is powerfully influenced by her belief that her son has not had, nor continues to have, schizophrenia. The manner in which she related to her son during the hearing was unusual and striking. Although her support of the Applicant during the hearing was admirable, she appeared to nurture him as if a much younger son. She was anxious to reassure him that he was correct when evidence was given conflicting with his accounts, or challenging his viewpoint. Her demeanour throughout the hearing was one of cynicism, and she rapidly dismissed evidence which conflicted with her own belief... The involvement of the Applicant's mother in his life is one and the same time a matter of reassurance and of concern. Her involvement is reassuring because of the high level of support she provides to her son. It is of concern because she lacks objectivity and understanding of her son's illness, which serves to delay necessary clinical interventions (Written decisions #38).

This kind of situation made it difficult for the MHRT to assist in any on-going enhancement of therapeutic relationships between the applicant and their responsible clinician.

6.5.4 Challenges from the applicant's lawyer

At any point after a witness has given their evidence and the panel have completed their questioning, the applicant's lawyer is given an opportunity to further question their testimony. Although the members described the hearings as inquisitorial, they also acknowledged that the extent to which this occurs in the hearing depends, at times, on the applicant's lawyer (Cf. Tribunal member #2).

During the observations of the hearings, some lawyers rigorously questioned the responsible clinician and key worker in an attempt to advocate for their clients. This was particularly the case when questioning the responsible clinicians about an applicant's legal status and living arrangements. In hearing nine (see box seven), for example, the lawyer obtained clarity around the tenancy agreement his client was under, which was conditional on the applicant being engaged with the mental health service:

Box seven. Challenging health professionals, hearing #9

Community Nurse: No, they said the Mental Health Act, to ensure that the medication was being taken.

Applicant's Lawyer: Right, you know if that was the position and you're relying on that, we should really have some evidence of that. We should have someone from [Community Residence] to provide that information. Because that's not in reports, it's just suddenly come in here now, saying that's a requirement of him staying at [Community Residence]. There's nothing before the Tribunal to support that.

After this line of questioning, the nurse and responsible clinician appeared to concede that the applicant could still honour that agreement as an informal patient. In hearing three, the lawyer asked twice if the responsible clinician supported the applicant's desire to have their status changed from an in-patient to a community treatment order. The point of contention, however, seemed to hinge on the applicant's desire to move into a boarding house or shared accommodation arrangement. The responsible clinician's view was the applicant would enjoy private accommodation, so as to avoid the negative influences of other residents, but accepted that they were supportive of the applicant's choice.

Hearing four in particular illustrated the dynamic manner in which some lawyers questioned responsible clinicians. This lawyer began by having the responsible clinician acknowledge point-by-point the positive improvements the applicant had made, which confirmed all the ways in which the applicant was supported by their husband, mother, and in-laws. Eventually, this line of questioning by the lawyer led to the more pointed question of the responsible clinician, as shown in box eight.

Box eight. Challenging the responsible clinicians, hearing #4

Lawyer: Mary [applicant] is saying give me a shot and let me try to show that I can be trusted. So why not try it? And in terms of even a therapeutic relationship, letting her show you that she can be trusted...

Responsible clinician: I think because Mary still says to me... I think she has both thoughts really; she said to me that she still really would like to come off all her medication, including oral, because she doesn't really think she needs them long-term. She also said to me that she does respect what I say and would intend to take her medication at this point –

Lawyer: Can I just stop you there because ... Isn't it really that she has some hope, that she could be well and is prepared to go along and trust you as a professional?

Responsible clinician: Yep

The applicant's lawyer then challenged the way the clinician used historical data on the applicant's behaviour to justify current decision-making of around their legal status. In box nine, this line of question is illustrated and shows how this then led to agreement that the applicant had not been admitted to hospital or had recurring delusions of a similar nature for several years.

Box nine. Challenging the responsible clinician, hearing #4

Lawyer: And you mentioned some delusion about the mafia, how long ago was that?

Responsible Clinician: That was a long time ago. That was, I think, the year 2000.

Lawyer: So that's eleven years ago.

Responsible clinician: Yes.

Lawyer: And if you look at the schedule that you attached to your report, Mary hasn't been an in-patient since, well really since the very beginning of 2004.

Responsible Clinician: That's correct, that's correct.

Such challenging questions by the lawyers helps the panel weigh the evidence when assessing the applicant's risk to self and others and/or capacity to self-care.

6.6 Final submissions

Before asking the applicant's lawyer to present their closing submissions, the applicant is invited to speak again. In six of the hearings observed the applicants took the opportunity to confirm their position and two chose to use the time to restate their earlier evidence, explaining they were not mentally disordered with the meaning of the Act. These two applicants reiterated that their condition was not caused by a mental illness, but a head injury or stress. Another two applicants challenged evidence presented during the hearing, either by disputing much of evidence presented in the clinical reports about their past behaviour by arguing that they had enjoyed good mental health for some time.

The applicants' lawyers largely presented brief final submissions in the hearing observed (see box ten) and reiterating information that had already been presented during the hearing.

Box ten. Snapshot examples of final submissions

Lawyer: I don't think I can say much else sir, I mean, I think Terry does want to be given a chance, he wants to be able to go, leave the care of the hospital and be able to live a life that he wants to lead (Hearing #5).

Lawyer: Adam denies he has a mental illness and denies he needs medication. He believes he is able to take care of his treatment and wants the freedom. He's fed up with being handled with care, he has free will and he says the doctor's depriving of his freedom. He's had no human voice for 50 years. Those are my instructions (Hearing #7).

Lawyer: Tom [applicant] is saying he will take medication. He wants the opportunity to demonstrate that he can do that (Hearing #8).

Some lawyers, perhaps more so than others, took this time to stress their client's perspectives as they were instructed, without shaping the original meaning or intention of the applicant's arguments. This was apparent, for example, in hearing four:

Box eleven. Final submission, hearing #4

Lawyer: Mary sees the over-protectiveness [by the mental health service] as being paternalistic and would like to have a more equal relationship with the professionals that are involved where she could choose (Hearing 4).

After restating how well Mary had been doing living in the community with her supportive family networks around her over an extended period of time, this lawyer took the opportunity to again point out their client's view of their treatment.

In none of the final submissions witnessed by the research team, did the lawyers draw on previous successful MHRT cases or cite reported cases to substantiate their arguments on behalf of the client to have their legal status changed. Additionally, in reviewing the written decisions it appeared some lawyers acted in a fatalistic manner, simply providing no closing submission at all.

During interviews, MHRT members expressed that there was variation in the standard of legal representation. For the most part, legal representation was considered to be adequate. It was acknowledged by members that cases before the MHRT often place lawyers in the dilemma of promoting the interests of their client in the face of most evidence running against their wishes.

> *I mean the lawyers often have a very difficult job because you will have some situations in which the patient's clearly somebody who is unwell and there is probably there's never any chance that their application is going to go anywhere (Tribunal member #13).*

The MHRT is also an inquisitorial process and aims to maintain therapeutic relationships between applicants and their responsible clinician. Lawyers, therefore, need to be careful in their submissions and questioning of clinical teams to not become too adversarial.

There were, however, cases noted by the members where legal representation was inadequate. Members reported observing some lawyers who did not make it clear on what grounds they were challenging the current legal status of their client or asked questions of the responsible clinicians that did not assist the applicant's position:

> *Some people don't – there's hardly any opening submission for a start so you're not even at all sure what the grounds for challenging are. Sometimes they really don't seem to know the Act very well and they're asking questions of the responsible clinicians that aren't actually going to help their client in anyway whatsoever (Tribunal member #10).*

A legal member discussed the rarity of the MHRT receiving a well thought out legal argument, which he thought was crucial given the final decision is a legal one:

> *...sometimes lawyers don't put as much work into a case as one might hope. It's rare that we get written submissions. It's rare that a lawyer puts a full argument to us...It's rather that the lawyer sort of sees their role is to come along and to put their client's view and challenge the evidence...and that is all important but it's not often that lawyers delve back into the law and you know, provide legal analysis. Because the final analysis is a legal determination....well they might do in their oral submission but not otherwise*

and I guess that make life more difficult in a way for the tribunal because we have to conjure up the arguments ourselves (Tribunal #1).

Other members described lawyers giving only the "bare bones" based on a brief meeting with the applicant just prior to the hearing (Tribunal member #6). In other cases they may not have met with the applicant at all.

The MHRT is reliant on good lawyering to ensure the process is experienced as fair and just by the applicant.

...you know even if the patient doesn't get the decision that they want, and of course in the vast majority of cases they don't get a decision that they want, but it's important they go away thinking they've had a fair hearings and they have been heard. And if the lawyer doesn't do very much they often end up going away feeling aggrieved at the process and feeling that what they wanted to get out there wasn't got out there (Tribunal member #6).

Inadequate legal representation, therefore, can disrupt the MHRT efforts to uphold natural justice by hampering the applicant's experience of having their voice heard and respected.

6.7 Deliberations

Once everyone has had an opportunity to speak, everyone is requested to leave the room in order for the panel members to deliberate on the evidence presented before them in the hearing. The research team was not approved to observe the deliberation process. The data on the deliberation process, therefore, is limited. The interviews generated some information on how the members approach deliberations and the factors they consider in constructing their final decision.

6.7.1 The existence of an abnormal state of mind

I have to say the main thing is the definition of mental disorder – so if the person meets the criteria under the Act. That's what we are there for really. To establish whether someone meets the discharge criteria or not, which is really just whether they're mentally disordered or not (Tribunal member #11).

During deliberations members must consider the applicant's argument alongside other evidence provided during the hearing and make a collective judgement as to whether the applicant meets the criteria set out in the legal definition for mental disorder.

The first step in this process involves assessing whether the applicants meets the first limb of the mental disorder definition – the existence of abnormal state of mind. A large majority of the tribunal members suggested that the existence of an abnormal state of mind is usually not a 'live' issue in most cases. Rather, the evidence provided by the clinician, and sometimes exhibited by the applicant during the hearing, clearly indicates the applicant meets the criteria:

Often the clinical evidence is clear enough and so the first limb of the definition is clear enough, easily satisfied. So there is an abnormal state of mind characterised by delusions and a disorder of perception, hallucinations, cognition, and formal thought disorder and so on...normally the identifying of one of those elements of disorder or delusion is easy because it's purely clinical (Tribunal member #1).

As well as clear evidence being present that establishes the existence of an abnormal state of mind, many applicants may not contest the first limb of the mental disorder definition (see section 6.3).

An important aspect of the mental disorder definition identified by the members was the link between the first and second limb. In particular, they explained that an applicant cannot be denied release from the Act if their abnormal state of mind is not *serious* enough in nature to cause risk to self or others, or their capacity to self-care.

6.7.2 Assessing risk and capacity to self-care

The next step in the decision-making process for members, and where they concentrated most of their deliberation time, was identifying serious risk factors, assessing the likelihood of these factors eventuating, and the determining the contextual factors that might protect against the risk factors in the absence of compulsory treatment. As Tribunal member #1 describes below, the assessment of risk and capacity for self-care involves the consideration of factors beyond psychiatric concerns alone:

> *Determining the issue of dangerousness – then that determination has to be having regard to what might happen within the social and psychiatric milieu of the person. So for one patient, were they to start having a relapse, then there would be endless family members and others who would quickly intervene. And the relapse would be nipped in the bud…their abnormal state of mind no longer presents as a serious danger to others because in the worst case scenario they would be supported and wouldn't develop to that point of dangerousness that they've demonstrated in the past (Tribunal member #1).*

Additionally, capacity for self-care has been conceptualised by the MHRT to encompass both individual and social considerations. This means attending to how the applicant can self-manage their individual needs as well as how successful they are in managing their life in the community (also see 'environmental factors' below).

The mental disorder framework was, therefore, reported by members as allowing for contextualisation of the risk factors relative to the applicant's situation:

> *Although it reads pretty simply, it's actually a complex question in that everyone has got a different level of family support or adherence to treatment, different levels of risk, different pathways to risk, different likelihood of being exposed to that pathway, different levels of stress tolerance (Tribunal member #10).*

The research team identified several factors that when combined appeared important in assessing whether the applicant met the criteria for limb two of the mental disorder definition. This included the applicant's history (past admissions, alcohol and drug use, violent behaviours, compliance and relapses), current insight into their illness, and environmental factors (independent living and social support).

1) Longitudinal history

In deciding whether an applicant should be released from compulsory treatment, the members discussed how an applicant's longitudinal history is important. By exploring the applicant's longitudinal history, the members described how they can construct a useful pattern of previous behaviour and identify potential risk factors:

> *Well you look at their psychiatric history, the probability of relapses and recurrence. The level of confidence that you have in the person's ability to carry through on what they*

say, I guess. And you look at risk factors, and try and bear that in mind (Tribunal member #3)

A detailed review of history was often included in beginning of the written decisions to provide a context around the applicant and give a basis for the final decision. Such inclusions of history were extensive, covering troubled childhoods, school attendance, first and on-going admissions to hospital, employment, relationships with family, and criminal activities. Excerpts from previous psychiatric reports were often included in the written decisions, providing details of diagnoses and their relationship to potentiating risk.

In some of the written decisions it was noted that opening submissions took issue with the overreliance of responsible clinician reports on psychiatric history.

> In opening the case for the Applicant, Mr Knox advised that the Applicant challenges both limbs of the Act's definition of 'mental disorder'. More specifically, Mr Knox submitted that the evidence/information contained in Dr Graham's report was historical and not reflective of the Applicant's current situation (written decision #43).

A member, however, gave his opinion as to the legitimacy of relying on a longitudinal perspective in making decisions:

We do take a longitudinal perspective and it's something that the tribunal often, I think, finds itself explaining to the clinical teams – that you're actually allowed to bring all of that into your consideration. So somebody is sitting in front of you at the interview doesn't have to be imminently unwell and/or dangerous. You know they could not be too bad, but they could be showing signs of decline and you know historically that when they decline they are very dangerous (Tribunal member #6).

So the historical patterns of decline in mental state and reasons for (re)admissions were important.

2) Compliance and 'imminence' of relapse

Linked in with longitudinal history is the degree of compliance an applicant displays with their treatment plan. Members interviewed provided numerous examples of hearings where applicants argued they would remain compliant with their treatment should they be released. The clinical team, however, then proceeded to provide evidence that this was not the applicant's true intentions:

They will say, "I will take my medication, you know, I accept the first limb [that I have a mental disorder]". Then you read the [responsible clinician's] report and it says that this person has never accepted that they have a mental disorder and [that] they've indicated to me, to the nurse out here, to the ward clerk and whatever that the minute they're off the Act they're not going to take medication again (Tribunal member #2).

Essentially, when considering the factors of compliance the MHRT weighs up the consequences of non-compliance and likelihood of relapse. Often the members focused on the speed of relapse, with more risky situations involving rapid relapse if the applicant was to stop taking their medications:

So what I'm taking into account there is the person's understanding of their illness, and linked to that often the issue of compliance. Linked to that what would be the consequences of non-compliance, like with what rapidity and with what certainty would there be a relapse. Is it a situation of maybe in 6 months' time they might become a little

unwell? Or is it a case that almost definitely after about 3 weeks they'll start becoming unwell? And then what is their environment such as to, you know how responsive is their environment to them becoming unwell? (Tribunal member #1).

A legal member described this as the 'test for imminence' which focuses attention on the question: how quickly will a person deteriorate if they stop taking their medication?

If the doctor says they could do alright after two or three years then they shouldn't be on the Act. But if the doctor says "look the history is that about six or eight weeks' time this is going to have worn off and they're going to be back in here...they're not fit to come off the Act (Tribunal member #7).

This same member described this as the most difficult aspect of their decision-making because it involved predicting: 1) whether the applicant will stay compliant and 2) the likely outcomes for the applicant if they were to stop their treatment. Long periods of wellness while under compulsion indicated to members that applicants were more likely to remain well if released (Tribunal member #10).

3) Insight into illness

The members' predictions of future compliance and relapses were inextricably linked to the level of insight the applicant has of their illness. A community member described insight as a level of understanding of illness that acknowledges the symptoms that may arise during a period of un-wellness, the factors that contribute to maintaining wellness, and the resources they had identified to call upon for support.

The members described different severities in lack of insight. Applicants who the members described as at the more serious end of lacking insight continued to have sustained denial of a mental illness, despite long periods of multiple hospitalisations and adverse events. In other cases, the degree of insight may be difficult to assume as completely lacking. Box twelve, for example, illustrates that Tyler acknowledged he was suffering from a mental illness, so he did possess some insight into his illness. There appeared, however, to be differences in how Tyler and Dr Jones understood the potential negative implications of Tyler's mental illness should he be released from compulsory treatment.

Box twelve. Questioning lack of insight, hearing #1

Legal member: The big issue seems to be Tyler's burning desire to be in the community. What is the main reason Tyler can't be released from the Mental Health Act today?

Responsible clinician: The main issue is a lack of insight. He doesn't believe he has a mental illness.

Applicant: What? Of course I've got a mental illness!

The kind of disagreement between Tyler and his doctor over the degree of lack of insight an applicant has is a common occurrence according to our analysis of interviews, written decisions, and observations of hearings.

The members described how they substantially rely on their questioning of responsible clinicians or key workers to formulate decisions on an applicant's insight where it is not so straightforward:

Well I think the applicant, they have varying degrees of insight, put it that way. Some of them have none really but some of them do actually have quite a bit. I think you rely on the other professionals that are there [at the hearing] (Tribunal member #14).

A psychiatric member described how levels of insight can be illustrated through the work the applicant has done to address significant risk factors that contribute to periods of un-wellness they experience:

And then you've got the patient's understanding, and their insight into their illness, and what they've done, and how much work they've done, you know on those issues. How much work they've done on the other factors like alcohol and drugs? What kind of living environment are they going into? All those sorts of things (Tribunal member #6).

Insight was not only considered as encompassing a willingness to acknowledge psychiatric diagnoses, but also the ability to recognise what helps the applicant to keep well and recognise symptoms of their mental illness should they begin to surface.

4) Environmental factors

Environmental factors such as living arrangements, social support structures and ability to manage daily activities contributed to members' final decision-making. The ability of the applicant to live independently and manage the day-to-day activities akin to most of the general public was considered pertinent to decision-making:

The Tribunal has often said that capacity of self-care means more than an individual's ability to care for himself or herself in the narrow sense of maintaining what clinicians refer to as activities of daily living (eating, cooking, cleaning etc). It is also used in the wider sense of managing within the community and maintaining an acceptable quality of life having regard to what might be expected of that particular individual (Written decision #32).

This directs attention to factors such as ability to carry out daily activities and maintain basic living standards most enjoy in regards to housing, employment, financial management and social relationships. During the observations, items that qualified as 'lacking in self-care' varied from not showering frequently enough (Hearing #8), dressing inappropriately (Hearing #3), having antagonistic relationships with church communities or family members to histories of becoming homeless.

The presence of social supports that will monitor the applicant's behaviour for signs of relapse was an important factor for the members.

A question that we quite often ask the applicants is what support you will have in your community. Who will tell you if you're starting to become overwhelmed? Because the applicant can be the last person who does and we want to know who there is [that support person] and what the person will do. You know, if there's a reliable person who is going to ring up the doctor and say, 'hey I think Mary is not taking the pills, you better send someone round' (Tribunal member #7)

The members also concentrated on whether or not the applicant would be open to sharing their concerns with family following recognition of signs they are becoming unwell.

6.7.3 Constructing decisions

> *On the one hand you want to acknowledge their [applicants'] integrity, or their autonomy, and so on. On the other hand, you don't want to make a decision for that patient that actually is not a good decision for that patient, that gives rise to them having another distressing hospitalisation...and of course, it may be resulting in, you know, a death of another person, you have to be careful and balance all these things up (Tribunal member #1).*

The members must then bring together the evidence to construct a final decision as to whether the evidence satisfies the legal definition of mental disorder and justifies the continued detention of the applicant under the Act. This involves a careful balancing act that considers all the factors outlined in section 6.7.2 alongside the rights of applicants to freedom and treatment. As Tribunal member #1 suggests, public safety featured strongly in the interviews and written decisions. Out of the 60 written decisions reviewed for this research, three were released. A close examination of these written decisions gives some insights into how the factors described above come together to construct a decision in the favour of the applicant.

Case one

In the first case the applicant agreed with her clinical team that she suffered from a long-term mental illness and all parties maintained that she was currently very well. She had been under a community treatment order for over four years, had a significant history with mental health services, and when unwell had experienced homelessness, self-neglect, and poor personal hygiene. Factors that were considered important for the panel included:

- *Living independently.* Evidence from the applicant and clinical team that she had been living independently for over 4 years without the need from readmission.
- *No current risk factors.* Most of the evidence provided by the responsible clinician detailing risk factors was historical and the responsible clinician confirmed the applicant was not experiencing any negative symptoms of her mental illness that led to risk factors developing in the past.
- *Good insight in her illness.* The applicant displayed good insight into her illness, the rationale for her continued need for medication, and how she would manage her health on her own. The applicant also acknowledged the vulnerabilities that led to her pervious admissions, identified the negative symptoms that occur as she begins to become unwell and outlined the support structures she would draw on if these symptoms where to arise again. This was largely confirmed by the responsible clinician report.
- *Compliant.* The responsible clinician agreed the applicant was compliant and expressed willingness to continue treatment.
- *Relapse not imminent.* If the applicant was to stop taking her medication, the likelihood of her experiencing symptoms to the point where admission to hospital would be required would take "some months" rather than a few weeks.

The panel decided the applicant did not meet the legal definition for mental disorder, particularly as her abnormal state of mind was not serious enough in nature to meet the second limb of the definition. The decision concluded:

> ...the Mental Health (Compulsory Assessment and Treatment) Act 1992 is a rights based piece of legislation. In our view, the notion of endless and unbroken compulsory treatment in circumstances as outlined in this case would conflict with the rights based tenor of the Act. The Act should not been used as a back-stop "in-case" a patient

> become[s] unwell in the future and where there is no serious or imminent danger to self, others or self care" (Written decision #59).

The applicant was released from her indefinite community treatment order of over 4 years.

Case two

As with case one, the applicant in case two also agreed that he had a mental illness, needed medication and positively acknowledged the continuation of voluntary engagement with mental health services would be required. The responsible clinician confirmed the applicant was still experiencing low-level symptoms of his illness and had continued concerns regarding the possibility of sexual re-offending. Factors that were considered important for the panel included:

- *Independent living.*
- *Compliancy and willingness to engage.* The applicant was compliant with his treatment and was committed to staying compliant. The applicant's key worker supported the view that the applicant would continue to seek the support of their team, including the responsible clinician.
- *Relapse not imminent.* If the applicant was to stop taking his medication the experience of symptoms would occur after a lengthy period of time.
- *Risk factors low.* The responsible clinician, and other clinicians, had indicated that the likelihood of the applicant re-offending was low.
- *Strong support.* The applicant had good support from his church community and had positive relationships with the key worker and responsible clinician who would be able to identify possible relapse early.

The panel concluded that the applicant was likely to remain well and although his offending was illness-related, the applicant's commitment to staying well would reduce the risk of re-offending:

> The Tribunal concludes in this case that although the *gravity* of possible sexual offending is serious, the *likelihood* of it in fact recurring in the future is low. The Tribunal reaches this conclusion essentially because soon after the Applicant was convicted for sexual offending he was assessed as low risk of re-offending, and since then, has achieved much improved mental health and stable patterns of independent living in the community with the help of medication (Written decision #41).

The applicant was released following being subject to an indefinite community treatment order for 8 years.

Case three

The applicant in case three accepted he experienced a mental illness in the past but was no longer suffering from any symptoms that could be classified as an abnormal state of mind and that matters of concern were historical in nature and could no longer be considered current risk factors. The applicant was strongly averse to being under the Act, was not positive about taking medication, continued to drink alcohol excessively and occasionally use marijuana. The responsible clinician reported the applicant had experienced a serious mental illness that led to violent behaviour in the past, but that he was no longer displaying serious symptoms. The level of insight the applicant had was considered low by the responsible clinician due to an unwillingness to continue medication despite its contribution to the applicant's mental health improving. Factors considered important to the panel:

- *No current symptoms*. The applicant did not display any symptoms that could be considered serious enough to lead to risk factors developing, despite the fact his medication had been significantly reduced by the responsible clinician over time.

- *Relapse not imminent.* It was confirmed by the responsible clinician that relapse following non-compliance would take several months.
- *Insight present.* The panel agreed that the applicant had some insight into the symptoms of his illness.
- *Strong support.* The applicant agreed to maintain contact with his key worker voluntarily and the key worker was confident he could monitor treatment and emergence of symptoms.
- *Voluntary mitigation of risk.* The applicant agreed to live independently away from his family member who has been vulnerable to his violent behaviour in the past.

The panel decided the second limb of the mental disorder definition in particular had not been met and provided the following reasoning:

> We hold the first limb established, but only on an intermittent basis...We note the applicant's delusions are not current or active. While we accept that it is possible that if they recur there is the possibility of risk to the applicant's mother, on the evidence however we do not consider that risk is imminent. The applicant has agreed to maintain contact with his key worker, and we accept that [his key worker] has confidence that will happen. The applicant has volunteered to remove himself from living with his mother, who is the only person about whom any risk is suggested. We acknowledge that there is the possibility of recurrence of symptoms...however he presently has good insight into this, and there is no guarantee that they will be recur. He will be monitored by [his key worker] (Written decision #40).

The applicant was released following being subject to an indefinite community treatment order for three years.

6.7.4 Disagreements, adjournments and reserved decisions

Most deliberations result in unanimous agreement amongst panel members, so examples of disagreements during deliberations were scarce. One psychiatric member described a situation in which the applicant's story led into discussions beyond the prescriptive decision-making of the MHRT.

> *...[T]here are some we've had quite a bit of discussion about but this one was actually quite interesting because I disagreed with both the community and legal member. It's like they got drawn into, I thought, the patient's story and then kind of moved away from the legal parameters. And it was me, as opposed to the lawyer, saying 'hang on, now the definition of mental disorder and maybe we should be focusing on that no, oh the poor thing', you know? They saw my point...we didn't end up arguing about it (Tribunal member #11).*

Members also reported 'borderline' cases that involved lengthy discussions before reaching a consensus. A decision of the MHRT can also be reserved when a panel *"don't want to commit there and then to a decision, because we just want to toss it over and think about it" (Tribunal member #1).* The same member described how they would then approach finalising the decision making process by the legal member drafting a written decision from their perspective and send to other panel members:

> *And so what I do in that situation is I write up the decision leading to a particular result. And usually from my perspective that clarifies it – once you start having to justify your decision, it becomes, you know, clearer as to what your decision should be. Then I send*

that off to them [the rest of the panel] and when they receive it…they think yeah that sort of makes sense and, you know, so it's done on that basis (Tribunal member #1).

The final written decisions of difficult borderline cases would then generally be brought up at plenaries and subjected to vigorous discussion with the wider members.

In a minority of cases, the deliberation process may result in a decision being adjourned due to lack of evidence. An adjournment may allow members to have certain facts confirmed:

There are times when there is a piece of historical information really about something that the patient is alleged to have done, which is a particularly risky behaviour, which is strongly disputed by the patient or their lawyer and we need to go back to the original source and find out if that's a crucial part of evidence. Usually it is pretty clear and we accept that consistent and clear clinical records are pretty factual. We occasionally need to go back to be clear about it but usually it's pretty accurate (Tribunal member #13).

Tribunal members gave examples of adjourning a case pending receiving further evidence in cases where they needed to hear from other health professionals, such as a responsible clinician or key worker, or required further clinical reports, information about an index offence or previous hearings.

We had a responsible clinician who'd seen him [applicant] once and although he was supporting the continued use of the Act, he was doing it in a fairly half-hearted fashion. We had a case manager who wasn't the person's normal case manager. Although they had the report from the normal case manager, we didn't think that was fair. We had misgivings about releasing this young man from the Act, but we didn't think it was actually fair to him to proceed on the information we had… So that was a huge problem at the time but we just adjourned it (Tribunal member #11).

6.8 Closing a hearing

In most cases the legal member orally presents the decision. How and who will deliver the panel's decision is open to negotiation and discussed during deliberations:

The panels I sit on generally…talk about how we're going to deliver it [the decision] and who would be best from the group to deliver it – it's not always the lawyer. Often it is, but occasionally we have decided it would be better coming from somebody else, often the lay member (Tribunal member #6).

During the deliberations, other panels took the opportunity to discuss how the decision would be delivered and what positive aspects could be added to encourage the applicant following the receipt of bad news:

We normally discuss what positives we've drawn from the hearing that we can draw for the patient… So people actually pick up qualities that the patient's presented with, a comment about how they've done well in the hearing maybe. Commented that, you know, we think that we found their contribution very helpful, and informative, and we think we understand… You know, we were very impressed by this particular thing you said, or by this that you're doing now, which seems to be an improvement on where things were at and we encourage you to carry on doing that sort of thing (Tribunal member #6).

The observation data illustrated constructive feedback and positive comment at the closing of hearings.

Box thirteen. Postive comments during closing of hearing, hearing #4

Panel member:	What we've heard today is that things have been going pretty well for you. You know, you're off to the gym and doing things like that, and that's great... I hope you continue the good work and that you achieve your goals as much as possible. You go for it!

A legal member added that speaking directly to the applicant about the final decision allowed the panel to create an environment where the applicant truly felt they took part in a fair, respectful and honest process. It also allowed the panel to deliver a disappointing decision in a way that did not leave them feeling powerless and hopeless:

> *...And in that you get to talk to the person, you get to look him in the eye and you get to explain yourself, and you say why you've done what you've done and so on. And you can often give a disappointing message in a way that does not leave them feeling shattered, despondent, downcast (Tribunal member #3).*

In hearing seven, the research team observed the ability of the panel to achieve this in practice, with the panel member carefully delivering the decision and receiving positive feedback from the applicant.

Box fourteen. Closing a hearing positively, hearing #7

Panel member:	Applicant, the Tribunal has heard what you've said this morning and we've actually come to a clear view that you're not fit to be released from the Mental Health Act. I'm not going to elaborate that view now because that may be distressing to you. So that is our decision and there is clarity about that decision and so you're still subject to this compulsory treatment order. We wish you well and we thank you for being so clear on your experience of these treatment arrangements.
Applicant	Yeah, thanks very much. I know you have to take everybody's perspective into your consideration so thanks very much anyway.

However, the observations of hearings also revealed the limitations of attempting positive reinforcement when also delivering bad news.

Box fifteen. The limits with closing a hearing positively, hearing #8

Legal member:	Our conclusion is that you do have a mental illness and that you do need to stay under the Mental Health Act....We wish you well. We are pleased that the boarding house situation is good for you. That's really great to hear....All the best and that concludes the hearing.
Applicant:	Thanks.
Legal member:	Okay.
Applicant:	How long is this going to be like this? How long do I have to be on this stupid –
Legal member:	You, you probably need to talk to your lawyer. But probably Tom, if the truth be known, you will probably need to stay on the order for quite some time yet. That's our view. Yeah.
Applicant:	But I was misdiagnosed.
Legal member:	Thanks and thank you all of you for coming along.

In hearing eight (see box fifteen), the legal member quickly closed the hearing following the applicant's response to the negative decision, leaving any further questions of the applicant to their representing lawyer.

The members openly acknowledged their inability to achieve a positive and empowering experience for all applicants. Most members were conscious that as much as they tried to conduct a procedurally fair process, this was significantly constrained by delivering a result not in accordance with the applicant's wishes. Even if members perceive a hearing was conducted with procedurally fair processes, the process may not have been experienced by the applicant as fair. This is particularly the case if applicants' judgements over fairness are inextricably linked to the outcome of the hearing.

> *The reality is in practice there are so many applications made a year, and there's only a few per cent which are successful. For the most part people are getting slapped down (Tribunal member #5)*

> *I think we make the processes not as – we try to make it not disempowering, but I think you really have to believe you don't need to be on the Act, you go through all the effort to go through what is quite a scary tribunal. I mean no matter how un-scary we want it to be, patients are quite intimidated by it and then you say, 'no, you're not off [the Act]'. I don't think some people think the whole process is empowering. No I don't (Tribunal member #11).*

In some cases, members had witnessed a decline in the condition of an applicant following an unfavourable decision:

The Tribunal is mindful about how the applicant is thinking about the case. So it's, I think it's not so much that we're engaging in therapy so to speak. It's rather that we are just want to remove or avoid any unnecessary distress or any negative consequence of the hearing. One possibility is an unrealistic expectation that then gets crushed and that might result in anger. So it's not unusual on a second hearing, or subsequent hearing, to see it reported that subsequent to the Tribunal hearing the applicant's condition deteriorated or the applicant was angry, distressed or whatever, despite best efforts (Tribunal member #1).

Comments contained within written decisions also suggested that some members see hearings as an interruption of therapeutic relationships:

> Current evidence indicates that the Applicant is now engaging more effectively in treatment, albeit that the District Court appeal and tribunal review proceedings have caused what are hopefully temporary setbacks (Written decision #10).

The members interviewed, however, maintained the importance of the hearings in allowing applicants to be given the chance to have their perspective heard by an independent body. Additionally, during the interviews it became apparent that closing the hearing also gave the MHRT the opportunity take a covert interventionist approach with clinical teams, by subtly suggesting changes that could be treatment plans:

I think sometimes there is that, you know covert, if you like, rather than overt, way of maybe just trying to get across to the team that there's something here that we're not very happy with. Or we think there are alternatives that you haven't considered, or something like that. So there is, you know, and you can bring those points out with a patient. You can say well, you know you wanted to talk about your medicine, or you wanted to talk about being an inpatient, or an outpatient. And we can't make that decision today, but you know you've had the opportunity of talking about it. We know that your teams heard about that, and that might be something that they want to think about with you. So, you know clearly we can't make decisions, or any recommendations about treatment. But I think in the way that you hold the discussion, some of those ideas can, they come up and then I think the way that you phrase your decision, you can impart messages, I guess back to the patient and the team (Tribunal member #6).

Although the MHRT does not have the legal powers to alter treatment plans, they indicated that the hearing process may potentially bring about changes for the applicant that addresses their core concerns.

Following the hearing, the panel then drafts a written decision. The legal member leads the writing of the written decisions, but the panel must have input and agree on its final form. The written decisions usually provide an overview of the applicant's longitudinal history, the evidence provided during the hearing, the panel members identification of risk factors, and final decision using the mental disorder definition. Positive comment detailed above was often included in the sample analysed for this study. The written decision is made available to the applicant, their lawyer and support persons and the clinical team. Only a select few are made available to the public due to the private nature of the quasi-judicial context in which MHRT proceedings take place.

6.9 Summary

This section reported the findings of the qualitative arm of this project. The interviews with members found they were passionate about their role of ensuring the rights of people detained for psychiatric treatment are weighed up against issues of personal and public safety. Overall, members understood the subjective nature of their decision-making, reflected in their recognition that the final outcome of the process was a legal judgement influenced by contextual factors, not a purely psychiatric determination. The three members described an equal contribution of the MHRT processes and decision-making. The addition of the community members was perceived as ensuring a more generalised perspective was added to the decision-making, complementing the specialised psychiatric and legal knowledge of the other members.

The members interviewed had many years' experience with the MHRT. Prior to joining the MHRT, the legal and psychiatric members had extensive experience in mental health law or related work with vulnerable individuals, and the community members had vast relevant experience in the health and social sector. Due to the previous experience members had, formal training was not considered necessary and many were appreciative of the documentation and collegial support provided by the other members.

Drawing on analysis of interviews, observations and written decisions, this section also detailed the processes involved with carrying out a hearing and, in doing so, highlighted members attempts to conduct hearings that were procedurally fair and just. Members acknowledged most decisions end negatively for applicants and so they significantly focussed their attention on ensuring the process leaves the applicant with hope and some positivity towards the future.

The members' ability to achieve the MHRT pro-therapeutic goals during the hearings was constrained by the practices of others involved in the hearings. The delivery of the applicants' evidence and closing submissions illustrated the variation in legal representation. All sources of data pointed predominantly to competent legal advocacy that provided well-presented legal arguments and critical questioning of responsible clinicians and maintained the inquisitorial nature of the MHRT. At times, however, it appears legal representation was less than optimal, with a lack of pre-hearing communication with applicants visible and a sense of fatalism in closing submissions. Psychiatric members were generally considered as integral to the questioning of responsible clinicians, and in carrying out their questioning all members were careful to avoid disrupting on-going therapeutic relationships. This was made difficult at times when it was clear the applicant and responsible clinician had a poor relationship or where responsible clinicians described the applicant's deficits in detail. At the same time, responsible clinicians who engaged well with applicants during the hearings, focusing on their joint decision-making and positive progress in treatment plans, were positively acknowledged by members. This type of engagement contributed significantly to the MHRT aims of convening a hearing that was experienced by the applicant as fair, transparent and which did not damage therapeutic relationships.

Evidence provided by the responsible clinicians and key workers was considered crucial by members. The factors considered in the deliberation process clearly point to a reliance on evidence provided in the responsible clinicians report and oral evidence provided during the hearing. Key workers were considered extremely important by members due to their regular interactions with applicants, highlighting applicants' social relationships, engagement with mental health services, and management of day-to-day living.

Decision-making during deliberation revolved mostly around limb two of the mental disorder definition. Although deliberation time was not often spent debating the existence of an abnormal state of mind, the consideration of risk and self-care issues clearly influenced

members' decisions regarding the seriousness of the abnormal state of mind. This means a person found to have an abnormal state of mind can be released from an order should the level of risk or self-care issues be low. In assessing the level of risk or self-care issues, longitudinal history, compliance, imminence of relapse, insight, and environmental factors appear important considerations for the members. Implications of the findings from the qualitative arm of this study will be considered in the next section.

7 Discussion and conclusion

This study drew on a variety of data sources to provide a detailed overview of the MHRT practices, processes and decision-making. The discussion section brings the findings of this study together with the current international literature on similar tribunals overseas, with the aim of highlighting both the positive characteristics of the New Zealand tribunal and areas for future consideration. The limitations of this report will also be detailed and suggestions for further research in this area are provided.

Overwhelmingly, the study found that members strived to produce a hearing that adhered to the principles of natural justice and therapeutic jurisprudence. The members acknowledged the limited number of hearings that result in the applicant being released, so they focused much attention on ensuring the applicant was left feeing supported and encouraged to carry on with their recovery. Members described how they 'set the scene' of the hearings to create a relaxed and inquisitorial, rather than adversarial, investigation. Members were cognisant of preventing situations where hearings created problems for the on-going relationships between applicants and their clinical and/or support persons. The observations and written decisions indicated that where possible, members provided positive feedback to applicants and during the interviews members described mediating potential conflicts. These findings strongly correspond with previous studies carried out in New Zealand (Diesfeld & McKenna, 2006) and internationally (O'Donoghue, et al., 2010; Yip, 2004).

The contribution of community members to MHRT processes has been considered by researchers to be vague and overshadowed by the alliance between psychiatric and legal members. Similar to other studies (Cf. Cavenagh & Newton, 1971), the community members in this study described their contribution as providing a perspective that was outside of the professional disciplines of psychiatry and law. Further, they saw their role as watching out for the general interests of the applicant and wider community. Viewing the applicant holistically was important to community members in this study and their explanations of their role offer insights that give some clarity the role – clarity that is missing from the current literature. Although the observations suggested community members did not question witnesses, particularly clinicians, as often as other members, the interviews with psychiatric and legal members generally indicated they contributed significantly to putting applicants at ease and eliciting contextual information for their decision-making. It must be noted that the exact contribution of the community member did seem vague to a few psychiatric and legal members interviewed, who considered themselves also members of the 'community'. Further consideration of service user input on the MHRT as community members was not an issue put to all members, but is worthy of further consideration.

Existing literature has criticised the decision-making of similar tribunals overseas for privileging medical opinion and being over-reliant on extra-legal factors. The findings of this study have indicated members do rely significantly on the reports and oral evidence provided by responsible clinicians. The MHRT rarely makes decisions that do not parallel the opinions of the responsible clinicians, indicated by only 7% of cases resulting in the applicants' release. The key factors they consider in their decision-making, such as longitudinal history, compliance, imminence of relapse and insight are heavily reliant on the evidence provided by both the responsible clinician and key worker. One limitation of this study, however, is that unlike previous research we have been unable to conduct statistical analysis of influential factors that might predict decisions due to the numbers released being so low and the incompleteness of the current MHRT database. In most cases it would be fair to say the evidence from the responsible clinician is the most persuasive element in MHRT decision-making.

The applicants' evidence does, however, feed into the decision-making of the MHRT. The study found that a competent lawyer who leads their evidence can ensure the panel members are directed towards the ways in which the applicant understands what keeps them well, how they manage to live independently, and what supports they have in place to carry through with their plans without the need for another admission to hospital. Members described their appreciation for clear opening submissions that were followed by a well thought out legal argument. References to previous MHRT written decisions and other relevant reported cases by some lawyers further strengthened the evidence of applicants. Inadequate legal representation, however, can disrupt the ability of the MHRT to obtain a perspective that is compelling and differs from the responsible clinician's evidence. Consideration of how lawyers working with applicants of the MHRT could be better supported to provide improved representation warrants further attention. Lawyering in this context varies significantly from other areas of law and involves the careful balance of advocacy, inquisitorial practices, and avoidance to heavy levels of paternalism in the "best interests" of clients.

Diesfeld and Sjostrom's (2007) critical analysis of MHRT written decisions found that some terms were used as shorthand for complex decisions. The term 'insight' was considered particularly problematic in the way it was used as a major justification of decisions to not release an applicant without any explanation of what it meant in the context of specific cases. The interviews with members suggested they do consider 'insight' in all its complexity, but often the intricacies and relative nature of this term were missing in the final written decisions. The observations indicated further ways in which 'insight' might equate to something more than purely the applicant's disagreement with the diagnosis given to them by the responsible clinician. The work an applicant had achieved in their pathway towards recovery and the willingness to co-operate with clinical teams, for instance, appeared to help members understand an applicant's level of insight.

The analysis of observations and written decisions indicated, however, a heavy use of medico-legal language in hearings that may not have been fully understood by applicants and it is of concern that this may be misconstrued as lack of insight. This is important given Carney's (2010, 2011) research has shown the importance of making sure applicants do not feel they are being 'talked about' more so than engaging in the discussion. At times applicants' arguments of the social 'causes' of their mental distress appeared marginalised over a preference for medicalised understandings. This was often exacerbated by the responsible clinician, rather than the members per se, but it seemed unhelpful and at times potentially invalidating for applicants who had a strong understanding that their mental state was the result of poverty, previous traumatic events or addiction. Examples were given by members of some responsible clinicians providing evidence in the form of a discussion with the applicant on areas on which they agreed or disagreed. This seems to be an approach that would ensure applicants' felt their voice was heard and that their perspectives of their mental distress were respected even if they did not accord with the responsible clinician's view. It would be valuable, therefore, if responsible clinicians could reflect on their role in achieving a hearing that acknowledges applicants' opinions and clarifies where they and the applicant hold differing views.

It was inevitable that assessment of risk was a significant feature of the members' decision making due to legal framework they are required to work within. The applicant's psychiatric history was a crucial factor in predicting the potential for risk to self or others. Historical acts of violence appeared to strengthen the probability of a decision not to discharge, suggesting the MHRT errs on the side of caution when there may be a possibility of risk to public safety. In her seminal work, Peay (1981) found that in cases where applicants had committed a dangerous act in the past, members became more conservative in their decision. Studies that have incorporated service user perspectives suggested applicants view tribunals as too easily

influenced by evidence of continued risk to the public (Dolan, et al., 1999). With many of the written decisions specifying applicants were under indefinite community treatment orders for several years, the research team were often left wondering when adverse historical events get to be considered just that – historical – and no longer a crucial factor in decisions to release an applicant from the Act. It must be noted that many of these concerns, however, revolve around the nature of the mental disorder definition in the Act. It is also acknowledged that the MHRT can only work within the existing legal framework and that members themselves may have concerns and suggestions for areas of reform. This report has not considered such suggestions.

An interesting finding in the study was the covert interventionist approach of some members. Psychiatric members in particular gave examples of reporting poor clinical practice by responsible clinicians to DAMHS or clinical directors. International studies have observed similar findings, with Richardson and Machin (2000a; 2000b) making the crucial point that examination of statutory criteria can unavoidably lead to a wider discussion of the patient's current care and future treatment plans. Additionally, this is perhaps likely to occur in MHRT hearings because troubled relationships between responsible clinicians and applicants may have instigated the application. Although comments on treatment plans is beyond the jurisdiction of the MHRT, discussions on medication regimes, possibilities for living independently, and access to help with trauma or addiction, seemed to directly tackle the needs of applicants and contribute to their perceptions of being heard. Whether this body should be able to independently review treatment plans is worthy of further consideration.

Many of the questions that arise from this study cannot be answered adequately without further research into applicants' experiences of the MHRT. It is not possible from this study's findings to make an assessment of whether members have a more favourable view of the MHRT than applicants. We only presume this is probably the case. It was significant that the members frankly and openly acknowledged the limits of the MHRT in leaving applicants feeling empowered given the intense nature of the hearing that results in mostly negative outcomes. The cycle of distress described by Ferencz and McGuire (2000) requires further consideration in the context of the New Zealand MHRT. Further, this study did not consider the perspectives of lawyers who represent applicants and responsible clinicians who have given evidence before the MHRT. This is an important area for future research given the variation in practice reported in this study.

Finally, a crucial limitation of this report is that it acts as a summary of the study's findings. In doing so, the research team has simplified an enormous amount of qualitative data collected over a three year period. Members did discuss, for example, the future of the MHRT and legislation reform ideas, giving their insights into important points for further consideration. The report does not detail hearings which reviewed applications under section 80 and 81 of the Act, which often involve the consideration of specific issues relevant to forensic dispositions. The research team intends to explore different aspects of the study in further detail and will publish such analyses in academic journals.

In conclusion, the MHRT can be easily subjected to criticism because of the low numbers of applicants released following review from this quasi-judicial body. This study has illustrated that the decision-making process is complex and cannot be adequately understood without observing the specific context that each decision is made. A written decision provides a justification for the outcome decided by the MHRT but leaves out the nuances gleaned from in-depth clinical reporting, inquisitorial investigation and unwritten observations during hearings. Although the MHRT process cannot be without its criticisms, we hope this report has highlighted the context driven nature of MHRT decision-making and the attention members give to the assisting in the production of positive consequences through the provision of support, encouragement and procedurally fair processes.

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