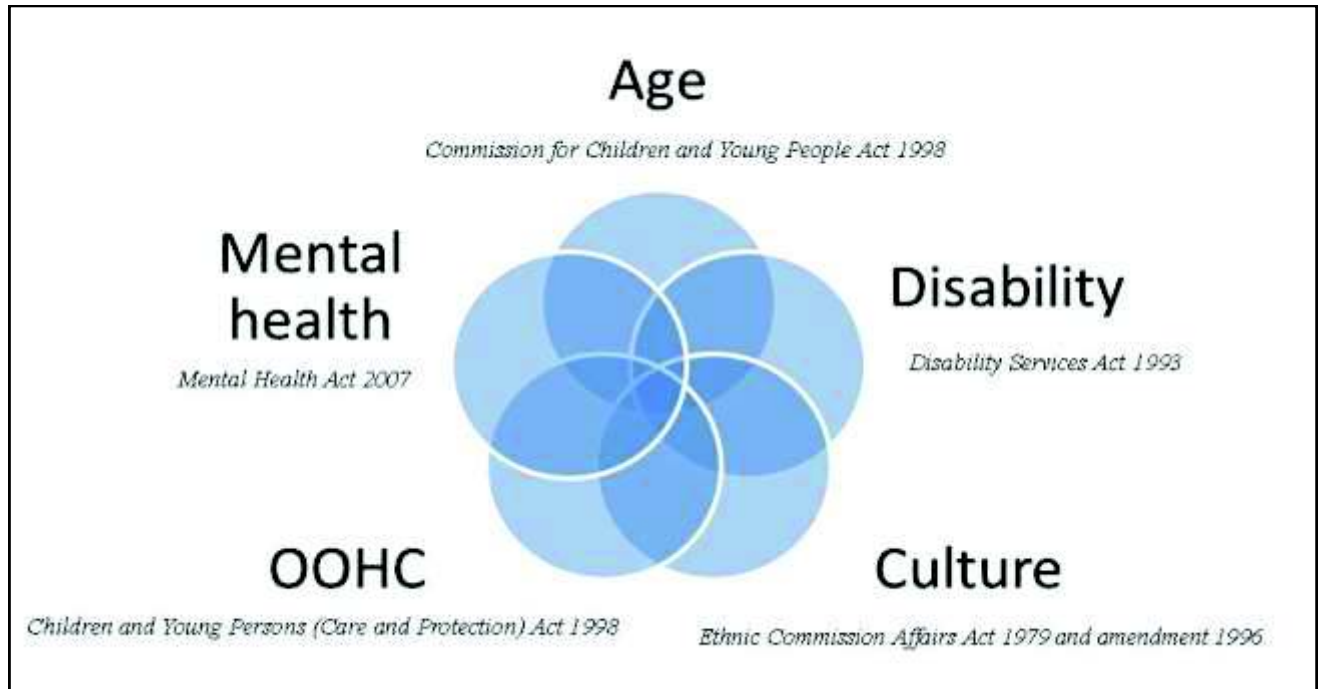


# Insight into a mental health review tribunal

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This article is based on an observation of a Mental Health Review Tribunal (MHRT) of an 11 year old boy under the NSW *Mental Health Act of 2007*. Some details have been changed to protect the identity of the child.

## What is a MHRT?

In NSW, a Mental Health Review Tribunal is a court-substitute tribunal where court like judicial power has been given, instead of purely administrative power of other tribunals (Rice & Day 2014 p.433-4), Advantages of the 'quasi-judicial power' that is held by the *Mental Health Act 2007*, include that they are not as costly or as time consuming as a court process (p.433).

Like an onion this case revealed multiple layers of vulnerability and clearly illustrated how the influences on mental health come from various bio-psycho-social domains, as diagram 1 (above) illustrates. The first layer was his age: a minor under the age of 16; the second layer involved his mental health episode of psychosis, bipolar disorder and experience of childhood trauma; the third, his level of disability Autism Spectrum Disorder and an intellectual disability; the fourth layer his guardianship status, as the parental responsibility lay

with the minister as he was a child in Out of Home Care (OOHC); and the fifth layer was his cultural background being from a non-English speaking background.

## Who is involved?

There are numerous professionals present at an MHRT. Firstly there is a tribunal panel. This consists of a Magistrate who chairs the meeting, a Psychiatrist, and one other, in this case a Social Worker. The role of the tribunal panel is to determine whether the patient is mentally ill and for whom no other care is appropriate (*The Mental Health Act 2007 s.38-1*).

The second group consisted of hospital ward staff: the treating psychiatrist, social worker, nurse, and registrar. Their roles were to 'give evidence about the need for the client to be on a legal order' (MHRT p.1). Turunen *et al*, suggest that psychiatrists prioritise medical rights over civil rights as the right to receive treatment with serious mental health problems, even when not asking for it, dominates (2001 p.39). In this particular case the side effects from the psychotropic medications the child was taking needed to be monitored daily, highlighting the pressing need for research into medication for children.

As the child was under the guardianship of the Minister, the third group of professionals present was the OOHC representative from NSW Department of Family and Communities (FACS). The main role of FACS was to ensure that the least restrictive practices were being made and the best interests of the child were being addressed.

The fourth group of professionals included a lawyer from The Mental Health Advocacy Service and his assistant. Their role was to advocate for the best interest of the child and in this instance they supported the medical team's application.

The final group present was the child and his support person, his long term foster carer, who also supported the medical team's application as she felt she could not manage the child's acute mental illness at home. His support person was able to voice her care related concerns. The child was unable to communicate verbally during the proceeding.

Mental health legislation can be discriminatory as it imposes significant limitations on liberty and autonomy of those who have a mental illness (Rice & Day 2014 p.283). Therefore it is fundamental to gain input from various representatives in the room. Rees acknowledges the skills and insights that this multi-member panel bring to the decision making process and the role of the tribunal in safeguarding 'the foundational human rights of freedom of movement and freedom of bodily integrity' (2003 p.42). The array of participants reflect the commitment to the quasi-judicial process and the reflection of the involuntary treatment as a last resort, as the *UN Principles for the Protection of Persons with Mental Illness* outline (Rice & Day 2014 p.274).

### Structure of the MHRT

The MHRT comes under the *Mental Health Act 2007* of NSW and under a civil as opposed to forensic jurisdiction. The order that was discussed in the observed

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## “The array of participants reflect the commitment to the quasi-judicial process”

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MHRT was a review of the Involuntary Patient Order S.37, as the initial 3 months of the original order was due to expire and the treating medical team were seeking an additional 3 months for continued treatment. The tribunal was held at the treating hospital, with the MHRT three member panel participating over video conference. The whole process took about 90 minutes. Paperwork is submitted several days before a tribunal, with verbal updates given on the day, followed by more paperwork after the event.

All participants of the MHRT tribunal were professionally dressed in appropriate attire without appearing too formal. The majority of conversation was in plain English, with a concerted effort to avoid medical jargon to make the process accessible. This is congruent with how Freckelton (2003) refers to language and questioning being straight forward and not complex. Similarly *The Mental Health Act 2007* stipulates that Tribunal meetings are to be held with as little formality and technicality as the act permits (S.151.1).

**Photo 1:** Example of a panel. Source: MHRT 2013.

Protocols that I observed were the use of 'your Honour', when talking to the Magistrate and not speaking unless you were asked a question or asked to speak. At the end of the tribunal, the panel gave the carer and the child the opportunity to ask any questions or offer any additional information.



## Is the MHRT open to the public or closed?

The *Mental Health Act 2007 (NSW)* states that 'The proceedings of the Tribunal are to be open to the public (S.151.3)'. An exception to this is if the Tribunal is concerned about the welfare of a person or if another person present requests, the Tribunal could order that the proceeding occur in private, or partly private and/or restrict the publication of the report, evidence or any other documents given to the Tribunal (S.151.4a-d). According to Nettheim, cases involving juvenile persons, marriage disputes or the guardianship of children need to be closed to the public (1984 p.25). There needs to be a balance between transparency and respect for the privacy of the child especially with acute mental illness, determining who is fit to attend and who can access documentation.

## Epilogue

The extra 3 months were granted pending a second opinion from an independent psychiatrist. This was gained and the child spent some time in hospital at which point the extension on the Involuntary Patient Order S.37 was ceased. The child is back with his carer and is still on medication. The staff commented that this stay in hospital was pertinent to his recovery. He is still being treated for his mental illness but has stabilised.

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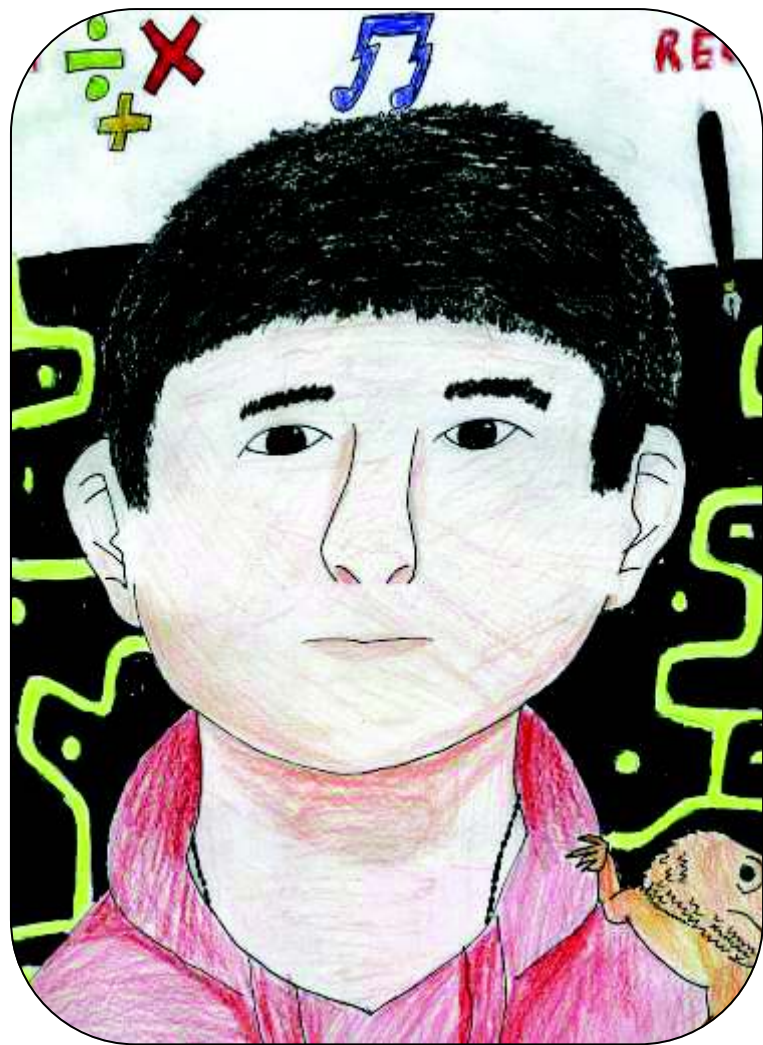
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