CLINICAL REFLECTION

Tribunal therapy: using the mental health tribunal to instil optimism

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First received 6 Jun 2023
Final revision 30 Jun 2023
Accepted 1 Jul 2023

SUMMARY

The role of mental health review tribunals is to oversee that standards of care and treatment are maintained for involuntary patients and for those on community treatment orders. This article considers some ways in which the basic principles of psychotherapy can be applied by tribunal members to offer patients a sense of hope, encouragement and optimism and reduce the emotional challenge of the tribunal review.

KEYWORDS

Tribunal; mental health services; clinical governance; psychotherapy; mental health review.

Mental health review tribunals are quasi-judicial bodies empowered by law to adjudicate on disputes concerning treatment, detention and care by conducting reviews of patients diagnosed with severe mental illness. In New South Wales tribunals are mandatory and held 6-monthly.

In most Western countries tribunals are presided over by an appointed lawyer, assisted by a suitably qualified psychiatrist and an informed community person.

The hearing is conducted as informally as possible, with both the patient and treating team in attendance. Prior to the hearing the treating team will have prepared a report for the tribunal's information, outlining the patient's mental state, diagnosis, treatment and prognosis.

Whereas the tribunal and the clinical team will be familiar with this process the patient may find it strange, perplexing or even threatening. Consequently it is important that the patient experiences the proceedings as supportive, unbiased and fair. The tribunal hearing may be the first time the patient has heard the members of the treating team giving an account of their formulation, diagnosis and treatment strategies. Whether or not the patient agrees with these conclusions is not the primary concern; what is important is that not only has he or she gained insight into the team's thinking but also there is opportunity for future therapeutic discussion and a sense of optimism.

Article update 7 May 2024.

Some lessons from psychotherapy

Frank (1993) has noted that the essence of all forms of successful psychotherapy, irrespective of theory, consists of three fundamental therapist characteristics, namely accurate empathy, genuineness and a non-possessive attitude, and extrapolating these principles to the tribunal is fundamental in establishing rapport with the anxious patient sitting across the table. Of equal relevance there may be some negative, even destructive styles that may create resistance and a failure to establish a therapeutic relationship. Meares & Hobson (1977) have defined several of these destructive styles of therapy, traps into which the inexperienced therapist may too easily fall, and described several destructive therapist–patient interactions. Two of these are of relevance to the tribunal–patient dialogue.

Intrusive questioning

First is the phenomenon of intrusion, in which the patient's personal space is invaded by crude interrogation in an attempt (usually well meaning) to extract a confession of some hidden symptom, truth or experience. This can be a problem with non-psychiatrically trained tribunal members, unaware of the subtleties and skills in elucidating the presence of hallucinations, delusions and paranoid ideas, the presence of which has already been identified by the clinical team, and forgetful of the fact that the tribunal's principal role is to adjudicate on disputes concerning treatment, detention and care.

Derogative questioning

The second damaging questioning style is derogation, a term used to cover the various ways in which an inexperienced therapist can denigrate the patient's ideas and opinions, unwittingly damaging their self-esteem and possibly impairing increasing insight.

Although it is not the role of tribunal members to be therapists, like it or not, as soon as they commence a conversation the patient almost immediately experiences an emotional response and

formulates an unconscious assessment of the questioner in which they may or may not experience the presence of an attitude of genuineness, non-possessiveness and accurate empathy. The tribunal interrogator may not wish to be seen as a therapist but the patient automatically senses a positive or negative transference that colours and influences the ambience of tribunal hearing.

The patient attitude

Many 'long-stay' patients, especially in a forensic system, will have attended tribunals previously. Some will see them as positive, even enjoyable, and anticipate them with a pleasurable affect, looking forward to sharing their experiences, grievances and hopes for the future with tribunal members they may have met on previous occasions. Sometimes they bring certificates or artwork for the perusal and approval of members.

Conversely, there are others who fear and dread the 6-monthly reviews and occasionally even refuse to attend. Although it may be the nature of the underlying disorders that deters them it is interesting to speculate that some may have previously experienced a negative tribunal hearing when they were subjected to intrusive and derogative interrogation by earnest overzealous tribunal members.

The treating team

The treating team have a difficult, sometimes conflicting task. Before the tribunal they have the onerous task of preparing a detailed report on the patient's history, treatment details, progress (or otherwise), prognosis and current mental state. This report contains details and opinions from all the various health professions involved in the patient's care and is the result of much interdisciplinary discussion.

Tribunal proceedings usually commence with the team psychiatrist being questioned about the report and subsequent questioning over certain details requiring clarification and elaboration. As the patient (and sometimes relatives also) is present, issues of confidentiality sometimes arise. There may be family 'secrets' that should not be disclosed concerning what are considered to be sensitive or taboo subjects and hence therapeutically damaging. This dilemma is well known to psychotherapists and requires delicate handling by the tribunal in order not to compromise the team's therapeutic endeavours.

Community treatment orders

Some patients, having recovered from a recent exacerbation of illness, are deemed fit for discharge but are known from previous clinical experience and the nature of their disorder to be likely to relapse unless closely followed up and given close care, support and monitoring in the community. In New South Wales, for instance, a community treatment order (CTO) is recommended if a person has a history of refusing to accept appropriate treatment following discharge. Recommendation for a CTO is made by the treating team but then has to be considered by the tribunal before it is enacted. Predictably, some patients will be angry about being put on a CTO, interpreting it as coercive, an infringement of their liberty and an expression of lack of trust by the clinical team and by the tribunal itself.

There is no easy solution to this dilemma and it has recently become more contentious following some long-term research studies claiming that CTOs are ineffective and fail to decrease clinical relapse any more than does good community care and support.

Conclusion

The role of the mental health tribunal is primarily to oversee that standards of care and treatment are maintained for involuntary patients and those on CTOs. It is not usually realised that tribunals also carry a complex unrecognised dynamic role of a quasi-therapeutic nature. This needs to be recognised, as in addition to involving the patient it needs to address complex issues, including the treating team's opinions and family dynamics.

Consequently the principles of what constitutes good psychotherapeutic questioning, such as accurate empathy, therapeutic genuineness and non-possessiveness, are of therapeutic relevance. It is important that tribunal members avoid interviewing styles that may incorporate attitudes of intrusion, derogation and other comments that could imply criticism and hence damage the vital impartiality and trust essential to tribunal hearings and respect for the patients fragile self-esteem.

By adhering to the basic principles of psychotherapy the tribunal can offer a sense of hope, encouragement and optimism for the future.

Author contributions

J.S. and M.B. contributed equally to the work.

Funding

This work received no specific grant from any funding agency, commercial or not-for-profit sectors.

Declaration of interest

None.

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