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Editorial

Mental Health Review Tribunals
Time for a change?

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The 1959 Mental Health Act allowed for the possibility of a detained patient to apply for a tribunal to review his or her detention under some circumstances. One of the most significant changes brought forward in the 1983 Mental Health Act was that it was recognised that in the interests of a patient's civil rights, this should be positively encouraged. This change, along with the introduction for the first time of an appeal in the 28 day assessment order, has led to a dramatic increase over the past 10 years in the number of applications for tribunals made to the Mental Health Act Commission, estimated by the Council on Tribunals (1993) to be 135%. The Community Supervision Order is accompanied by an appeal right similar to that of Section 3, augmenting the role of the mental health review tribunal system in protecting the rights of detained patients. The cost of mental health tribunal has been estimated to be around £12 000 000 per year (Blumenthal & Wessely, 1994*c*), and this is likely to escalate if current trends continue.

There are concerns from psychiatrists at the increased workload involved in the preparation needed for tribunals, and assertions from the Royal College of Psychiatrists (1995) that this should not be delegated to juniors in training without appropriate supervision. Bradley *et al* (1995) have questioned the fairness of the current system, claiming that it does not satisfactorily protect patients' civil liberties. Eastman (1994), reporting on a conference organised by the Law Society, Mental Health Act Commission and the Institute of Psychiatry, concludes that radical legal reform is necessary, and emphasises the concept of reciprocity, that is, removal of civil liberties must be matched by adequate provision of services. Few countries in Europe have a similar system, most relying on legal rather than quasi-legal procedures. This paper attempts to review the studies which have been undertaken to date on the procedure.

The Act (1983) allows patients detained to apply for a hearing at which the tribunal panel (consisting of lay, legal and medical members) will hear reports prepared by the Responsible Medical Officer (RMO), and a person, usually a social worker, who can give an account of the patient's social circumstances. In addition, the panel may hear from the patient, and his/her nearest relative. The patient may have legal representation, and despite reductions in legal aid, this occurs in an increasing proportion of cases – 82% of tribunals in a recent study by Blumenthal & Wessely (1994*a*) compared to 65% in 1989. Legal representatives may request an independent psychiatric report; while this is currently a relatively rare occurrence other than in special hospital patients, it is likely to increase in light of the positive association found by Blumenthal & Wessely (1994*a*) between an independent psychiatrist's report and discharge. These latter two factors, which are likely to become an increasingly prominent feature of tribunals, have the effect of increasing the delays in holding a tribunal, as well as changing the nature of it towards a far more adversarial procedure, increasing the anxieties of clinicians, and perhaps also patients at the tribunal.

Criticisms of the current tribunal system

Despite the benefits of the new Act, critics such as Peay (1983) were quick to point out that the changes represented a procedural safeguard only, and Wood (1993) has pointed out the limitations of the tribunal, particularly the lack of influence on issues such as quality of treatment, placement, and issues of the timing of hearings. Assessment orders (Section 2) last only for 28 days, and thus it is a statutory requirement that the tribunal be heard swiftly, although the gain may only be a few days of extra liberty if the patient is discharged. The pressure put on the Mental Health Act offices as a result of the large numbers of assessment order tribunal applications has been one factor cited by Blumenthal & Wessely (1994*b*) for the delays, sometimes excessive, in the treatment order (Section 3) hearings, and have persuaded some (Wood, 1993) that an alternative procedure, such as an

'emergency' review by the medical member alone, may be more appropriate in an assessment appeal.

A study of decision-making under the Mental Health Act, commissioned by the Department of Health and Social Security, was undertaken in 1989 by Peay. Attempting a descriptive study of decision-making, tribunal hearings were attended, and accompanying documentation examined. In addition, a number of others were interviewed during the process of the research, including patients and professionals. Peay concluded that rather than exercising choice between real options, the tribunals invariably endorsed recommendations made to them (86% reaching a decision which paralleled the RMO's conclusion), often employing retrospective strategies for justifying their decisions, which were of dubious validity. It seemed that rather than acting in accordance with the law, they often seemed to take a more common-sense attitude, being cautious in discharging patients who were perceived as dangerous. (The focus of her work was directed, although not exclusively, towards patients detained in special hospitals.) While this may seem acceptable to some, particularly medical professionals who are used to working in a pragmatic manner, it will certainly not satisfy the European Court of Human Rights, who were instrumental in bringing about the changes of the 1983 Act, in order to increase the rights of those people of 'unsound mind' who are lawfully detained. Drawing on Peay's work, Roberts (1991) has argued that some of the unsatisfactory findings were the result of the difficult transition period following introduction of the 1983 Act, and of inadequate material resources at that time. Since then, he suggests, Mental Health Act offices are better resourced, and further training has ensured that tribunal members are better informed as to their role.

One concern in recent years has been the fact that many tribunals are not being held within the specified time period. A survey commissioned by the Department of Health conducted nationally by Blumenthal & Wessely (1994*b*), found that there was no one factor responsible for delay, the main components being the complexity of the case, special hospital status, restriction order, and the use of independent psychiatric reports. Of more concern, perhaps, was the finding of dissatisfaction with the tribunal within all professional disciplines. RMOs found the adversarial attitude of the legal representatives stressful and potentially detrimental to the doctor–patient relationship. They found the work involved in a tribunal (writing the report and attending the tribunal hearing) detracted greatly from other clinical duties, with the result that the work was often delegated down to junior staff (despite this being specifically discouraged by both the Department of Health in the code of Practice (1993) and the Royal College of Psychiatrists (1995)). Tribunal members clearly acknowledged their own dissatisfaction with the procedure, lay and legal members felt that they had not had sufficient training in mental health issues, and most members found the limited powers that they had (to discharge or not to discharge) frustrating. Perhaps the most glaring omission in the current procedures is the lack of any feedback available to the tribunal. This is clearly frustrating to them, and further restricts the opportunity of learning from past actions, but is also a source of frustration for the RMOs, who perceive the tribunal members as not being accountable for the consequences of their decisions. This is one of the few studies which has attempted to look at patients' attitudes, and it was reassuring to find that despite these shortcomings, patients themselves found the tribunal both fair and useful. Although Webster & Dean (1989) enquired into patients' understanding of their rights, and the opinions of relatives regarding the sectioning itself, the only other work with patients has been done by Peay (1989), finding that although most patients found the tribunals fair, they had low expectations with regard to the powers they felt the tribunal had. Although the nearest relative has the right to attend and increasing numbers are taking up this right, no work has been done looking at their perceptions of the process.

Patient variables and outcome

Relatively little work has been undertaken on the demographic or diagnostic features of patients who undergo tribunals. Spencer (1989) reported on 50 consecutive tribunals in 1989, finding the rate of discharge to be 15%, and finding that patients with manic–depressive psychosis were more likely to be discharged than patients with other disorders. O'Dwyer & Neville (1991) looked at a series of patients detained under assessment orders (Section 2), finding an appeal rate of 9%, and a discharge rate of 16%. Although the numbers were small, and there were no statistically significant differences, they commented that five out of the six patients discharged were female, that they were older than the non-discharged group, and that none of the successful applicants was Asian despite 15% of the applicants being Asian. In neither of these studies was follow-up attempted; however, Wilkinson & Sharpe (1993) have reported a small retrospective

case-note study, looking at outcome of patients discharged by a tribunal. They found an appeal rate of 9%, and a discharge rate of 17% (representing 12 patients). A poor outcome was found in five of these 12, outcome being measured in terms of compliance with medication or with planned after-care, and the incidence of untoward events (readmission in two patients and suicide in a third). As the analysis by Spencer (1989) found that patients with mania were most likely to be discharged, of particular concern was the finding by Wilkinson & Sharpe (1993) that all untoward incidents occurred in patients with mania.

The responsibilities of the RMO at a tribunal have been set out and explained on several occasions (Brockman, 1993; Langley, 1993). The difficulties likely to be experienced by RMOs or their juniors are detailed by Woolf (1991), who notes that doctors may find the questioning by legal representatives searching, and be unused to having to defend their opinion in front of patients and relatives. Blumenthal & Wessely (1994*b*) found that many clinicians experienced the tribunal as untherapeutic, 44% saying that tribunals created conflict and antagonism, particularly as doctors must attempt to maintain a good working relationship with patients for many years to come. This problem has been recognised by the Commission, and tribunal presidents are instructed to intervene when questioning becomes unnecessarily adversarial. Nevertheless, several authors (Peay, 1989; Roberts, 1991) have noted that a significant proportion of tribunals are cancelled at short notice prior to the tribunal, and it has been postulated that RMOs may take a decision to avoid the conflict and/or considerable time and effort in preparing for a tribunal, by discharging the patient from section earlier than they would otherwise have done. It is not known whether the outcome of such patients is better or worse as a result of this; either could be convincingly argued and further research in this area would be valuable.

Alternative procedures for tribunals

To address some of the problems with the current system, and in particular to make review of detention more efficient, a number of proposals have been put forward. Wood (1993) has proposed an alternative procedure of 'emergency review' by the medical member of the tribunal only, but this is unlikely to satisfy the conditions of the European Court of Human Rights. More recently, it had been suggested that Section 2 orders be lengthened if patients are known to have suffered previous breakdowns (Wood, 1995), however this would augment current concerns that patients are being detained without satisfactory protection of their civil liberties. There is already a parallel regulatory system in operation – the Managers' hearings. These tend to be less formal and discharges are infrequent. Their intervention is not yet fully integrated into the system and no evaluation has yet been undertaken. Rather than duplicating the work of the mental health review tribunals, it has been suggested that their role be developed to perform this initial automatic review which Wood proposes (Crimlisk & Phelan, 1995), however, there are difficulties with them being given an extended role, in that they lack the independence of an outside body, and will therefore be seen by some as being inadequate.

Conclusions

The Department of Health has recently commissioned a study on decision-making processes and outcome of mental health review tribunals, which may clarify some of the outstanding questions. There seems, however, to be widespread dissatisfaction with the current mental health legislative system in general (Eastman, 1994), and recent media interest in the criminality of mentally ill people makes it likely that the debate will continue. With the advent of community care, there is a need for a Mental Health Act which is based on admission to a service, rather than admission to a hospital, and many are now calling for wide-reaching reform of the whole system (Anon, 1995).

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