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Mental Health Review Tribunals in practice

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Effective participation in the work of Mental Health Review Tribunals (hereafter the "Tribunal(s)") held under the Mental Health Act 1983 (MHA) requires a knowledge and understanding of detailed points of law, and practice. This summary and commentary may be of assistance to new or infrequent participants.

Practice is considered as it applies to:

(a) preparation for the hearing
(b) the hearing – outcomes
(c) the hearing – practice
(d) decision making and communication.

The law is not reported in detail and reference should be made to the Act itself, or an annotated version (Jones, 1988) and particularly to Sections 72 & 73, and the Tribunal Regulations (SI 1983, No. 942). The *Mental Health Act Manual* published by the Department of Health in 1987 is useful but has no statutory force.

Preparation for the hearing

Reports

Reports *must* be prepared for the Tribunal by:

(a) The Responsible Authority
(b) the Responsible Medical Officer (RMO), and
(c) a person who can report on the up-to-date social circumstances of the patient
(d) the Home Secretary (if the case is restricted under S 41).

Reports *may* also be offered by:

(a) an independent psychiatrist
(b) others.

Reports will receive better consideration if they are available to Tribunal members before the day of the hearing.

The Responsible Authority's report

The contents are detailed in Part A of the Schedule to SI 1983 No. 942. The information given should be accurate, complete, and include dates of *all* previous Tribunal hearings, the name of other medical practitioners who have recently been largely concerned with the care of the patient, and details of leave of absence granted during the previous two years.

Nothing in the Regulations confines these comments to the current period of detention. It is necessary, where relevant, to include information from other hospitals and previous admissions. Although not specifically requested, details of all previous periods of detention are extremely helpful.

The Responsible Medical Officer's (RMO's) report

The RMO's report, more by custom than regulation, will normally be taken to represent the views of the health authority (as MHA Managers) on the suitability of the patient for discharge (SI 1983 No. 942 Schedule B, 3). It should be written and presented by the RMO or, with his authority, by a senior colleague. Comprehensive advice on writing a report is given elsewhere (Brockman, 1993). The report and presentation should be based on a recent interview with the patient (not always so in practice). It will be disclosed to the patient in full unless the RMO advises, and the Tribunal agrees that, in the patient's interests, parts be not disclosed. Such parts must still be seen by the patient's representative. It is helpful if the RMO discusses his report with the patient before the Tribunal commences.

After giving the history the report should systematically address the legal criteria which the Tribunal have to consider under S72 or S73.

It is helpful to describe why the patient was detained, but this is not a matter of prime concern. It is the necessity for, and legality of, continued detention at the time of the hearing that is important. When there is a delay between writing the report and the hearing, the report will need to be updated by either a written supplement or verbally at the hearing.

A common misconception of the law also should be avoided. In S72 (a) (ii) & (b) (ii) note the first "or", i.e. it reads health or safety or the protection of others. It is common for the first "or" to be cited as "and", which is incorrect and misleading. The Act is

quite clear that 'health' alone is sufficient for this subsection to be satisfied.

If the Tribunal is not convinced that they *must* direct a patient's discharge, they *may* still exercise their discretion to do so. With this in mind they will wish to be concerned firstly with the patient's *treatability* i.e. "the likelihood of medical treatment (in the broad sense of S145) alleviating or preventing a deterioration of the patient's condition," and secondly, when the patient is detained because of either mental illness or severe mental impairment, with *viability* i.e. whether, "if discharged, he will be able to care for himself, obtain the care he needs, or to guard himself against serious exploitation" (S72 (2) (a) & (b)). It follows that the RMO should address these issues.

Treatability has two components, "Alleviating" or "Preventing a deterioration" in the condition. Either will suffice and of the two preventing deterioration alone is the minimal set. The broad definition of medical treatment under S145 also has to be recognised.

The RMO who prefers a very brief report should realise that:

(a) only written or oral evidence as presented can contribute to the Tribunal's decision and
(b) compared with oral evidence, it is easier to control written evidence that is considered detrimental to the patient's health.

Essential points not made in writing will have to be established in oral evidence, thereby prolonging the RMO's contribution. Attempting short cuts by reference to other reports means that these reports must be disclosed to all interested parties. It is wise not to include third party reports or letters without the authors' permission. Referring to the case-notes in a report may lead to a call for them to be similarly disclosed to all parties. Normally the case-notes are seen only by the Tribunal's medical member. RMOs should consider whether they wish to deliberately alter this practice by the wording of their report. Reports should not be passed to the patient's representative (other than some reports from the independent psychiatrist) that are not also passed to the Tribunal.

Appropriate legal terms should be used, particularly in respect of section 1 definitions and the "and"/"or" distinctions noted above. Internal inconsistencies can creep in. The RMO who gives non-compliance with medication as a reason for continued detention is not convincing if, at the same time, he is treating the patient under a certificate of consent (S58, Form 38), that he himself has issued.

A Tribunal may not agree with an RMO, or may wish to test his opinions, but they will be much influenced by clearly expressed views backed by reasons for holding them.

The social circumstances report

The content, but not the author, of this report is determined by Part B of the Schedule to SI 942. It requires knowledge of the patient's home and family circumstances, the attitude of the nearest relative, and, if the patient is discharged, opportunities for employment or occupation, housing, community support, financial circumstances and relevant medical facilities. It is commonly given by a social worker of the appropriate local authority (LA) on the basis that it is the LA that is responsible for after-care.

With the community orientation of psychiatry and social work it is not uncommon for the reporting social worker to have, and to admit to, relatively scant first-hand knowledge of a detained in-patient's affairs. More knowledge is often held by a community or hospital psychiatric nurse, who is rarely present, and has different skills and authority. Occasionally a report is submitted by a psychiatric nurse, but arguably a report should be asked for routinely either to replace or supplement the social worker in providing the information and evidence required by law.

As with the RMO, the report should address the relevant legal points, as well as providing facts, and offer reasons in support of the views held. The writer may request portions to be withheld if considered detrimental to the patient's health.

The Home Office report

In case of a restricted patient the Tribunal must consider a report from the Secretary of State for the Home Office who, prior to issuing his report, must see *all* documents submitted to the Tribunal. Failure to submit reports to the Home Office in time for them to comment may lead to delay or adjournments. In his report the Home Secretary will summarise the circumstances of the index offence, comment on the statutory reports of others, list previous convictions, and offer his opinion about the suitability of the patient for discharge.

The independent psychiatrist's report

The independent psychiatrist (IP) is called by the patient's representative, and is authorised by statute to visit the patient and examine documents (S76). His report will be sent to the representative who will then discuss it with the patient and with his approval send it to the RMO to be agreed. As with the RMO, parts may be withheld from the patient on health grounds.

If the report is agreed, it should be copied to the Tribunal office for transmission to members; if not agreed, the IP may have to be called to give evidence personally. If it is not to be submitted to the Tribunal, but a copy is sent to the RMO, and filed in the case-notes, it may be seen by the Tribunal medical member (MM) at the time of the preliminary examination. The MM is then placed in a difficult position

regarding disclosure to other Tribunal members. It is better that he is not given the opportunity to see the report.

Other reports

Reports (and more frequently, oral evidence) may also sometimes be submitted by community and ward nurses, other consultant psychiatrists, and other carers (e.g. residential) workers. Some may be independently commissioned. Persons reporting are free to offer any relevant information, sometimes of limited scope, e.g. the applicant's behaviour in, and acceptability for, after-care accommodation.

Other preparations for a Tribunal

The Medical Member's preliminary interview

The medical member (MM) does not prepare a formal report. In advance of the hearing he must (Rule 11 – "shall") examine the patient and the medical records in order to form an opinion of the patient's medical condition. Then, either immediately before or after the hearing, dependent upon the President's wishes, he may report in private to the Tribunal. In coming to a decision, members can take into account only such matters as have been brought openly before the Tribunal, and are therefore open to challenge. Jones (1988), citing R v MHRT ex.p. Clatworthy 1985, notes that any evidence or information which has only been made available to the MM must be shown at least to the patient's representative. This would seem to include the case-notes!

The MM's preliminary interview is statutory. The applicant who does not wish to be interviewed is effectively aborting his Tribunal. As a direct act this is rare, but the problem is real when a patient goes absent without leave or fails to return from leave in time for the examination. MMs will make every effort to liaise with ward staff to prevent such events, but hospital staff must take their own share of the responsibility for ensuring the patient's presence.

Administrative preparation

Many prosaic matters can influence the smooth running, if not the decision, of a hearing. A clean, warm and quiet room should be available with nearby waiting accommodation of equal comfort. Most Tribunal members and clerks are now aware of the particular hazards of parking, payment and clamping at each hospital visited, but a briefing sheet, including how to get there, would be appreciated.

The scheduling of hearings

The scheduling of hearings held on the same day resolves itself into making decisions about priorities. Whose time is most valuable? 'Day before' liaison between clerks, managers, and representatives can be productive. The Tribunal members have to be there from start to finish, but the issue for them is whether there are gaps in the proceedings when early hearings are short or aborted. For members, witnesses and representatives the cost of delay in time (and in legal aid fees) can be considerable.

The hearing

The Tribunal is not a Court. The procedures are informal and the rules of evidence used in Court are not strictly applied. The Tribunal may, exceptionally, take evidence on oath and subpoena witnesses.

For a comprehensive account of Tribunal procedures see Jones, (1988) and Peay (1989). Only the outcome options, and some of the factors influencing them, are recorded here.

The possible outcomes

The task of the Tribunal is to consider, in the light of the statutory criteria laid down in S72 & 73 the necessity, or otherwise for continued detention in hospital, or liability to detention. The Tribunal's options for action are limited firstly to *directions*, which must be implemented, and secondly to *recommendations*, which are considered by the detaining authority, but are not enforceable by the Tribunal.

If it comes to the Tribunal's notice that an irregularity casts doubt upon the legality of the detention, and therefore of their remit, they will adjourn until the hospital managers can confirm the validity of the detention.

As procedures vary between non-restricted and restricted cases these classes will be considered separately.

Non-restricted cases

Directions

Mandatory discharges. In certain circumstances Tribunals *must* direct the discharge of the patient (see S72 & S73).

Problems can arise if the circumstances mandating action are not understood. The RMO who recommends continued detention and then states, for example, that the applicant is not suffering from mental illness is scoring an 'own goal'.

Discretionary discharges. When the Tribunal do not consider that the patient *must* be discharged, and then only when the patient is detained otherwise than under Section 2, the Tribunal may still direct the discharge of a patient. In this case, under S72 (2), the Tribunal 'shall have regard to' (a) treatability and (b) (for mental illness and severe mental impairment only), viability.

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When discretionary action is being considered, and after-care needs figure prominently, the Tribunal will seek informed responses from consultant, social worker and/or community psychiatric nurses about behaviour and resources.

Delayed discharges. Otherwise than for detention under Section 2, the Tribunal may, (S72 (3)), specify discharge at a future date so that suitable after care arrangements can be made. Once such a direction is made it cannot be varied, so it must be apparent to the Tribunal that the patient is already fit for discharge on the day of the hearing; the delay is not for further trial or observation, but only for arrangements to be made.

Recommendations

Tribunals operating with non restricted patients, if they do not discharge the patient, have a statutory right to make recommendations to the RMO and hospital managers about leave of absence, transfer to another hospital or transfer into guardianship. They may not impose such recommendations, but may further consider the case if the recommendations are not complied with within a specified period.

Restricted cases

Directions

For patients whose discharge is restricted under S41, discharge by a Tribunal sitting under a Judge, may be either (i) absolute or (ii) conditional (S73, 1 & 2).

Absolute discharge. To discharge a patient absolutely the Tribunal must be satisfied that his mental state does not justify continued detention, or liability to detention, in hospital *and* that is not appropriate for him to remain liable to be recalled to hospital.

Conditional discharge. If the Tribunal is satisfied that the applicant does not justify being detained, or liable to be detained, in hospital, but should remain liable to *recall*, they must direct a conditional discharge, and impose such conditions as are necessary. A conditional discharge may also be deferred, as above, for arrangements for after care to be made. A person who is free from mental illness may be conditionally discharged and remain liable to recall.

Medication cannot be enforced during a conditional discharge, but compliance with medication can be a condition that, if broken, warrants the patient's return to hospital.

The use of the double negative in Ss 72 & 73 led Peay (1989) to opine that in practice, and unnecessarily so, the burden of proof is raised from "balance of probabilities" to "beyond reasonable doubt".

In the above, "discharge" means discharge from the section and not transfer to another hospital (unless informally). If not satisfied about the criteria for discharge laid down by law, the Tribunal's final option is not to discharge the patient.

Recommendations

There are no powers to make recommendations about restricted patients heard under S73, but the Secretary of State has accepted Tribunals may so recommend (MHAC, 1983–5). They may be directed to both the RMO and the Home Office but their authority is relatively weak.

Practice at the hearing

Representation

Any party appearing at a Tribunal may be represented by any person (SI 942, Rule 10(1)). The legal patient's representative will conduct any preliminary negotiations with the Tribunal about procedure. Normally only the patient is represented. In these circumstances other witnesses may feel threatened but good preparation will stand them in good stead. Legal representatives should recognise the informality of a Tribunal. If all else fails, it is up to the President to protect witnesses, although some Presidents feel that this detracts from their impartiality. During the hearing the representative will put the client's case to the Tribunal and, after all the evidence has been given, will make a final plea on behalf of the client.

Attendance

Tribunals are not normally held in public but, at the patient's request, a public hearing may be held, if the Tribunal is satisfied that it is not contrary to the patient's interests. During the hearing private interviews with the Tribunal are possible but normally the patient's representative will remain, if not the patient. The Tribunal may exclude from the hearing, or part of the hearing, any person other than the patient's representative and in certain circumstances must then give written reasons to the person excluded.

The independent psychiatrist (IP)

The IP will be examined by the Tribunal as any other witness and it will be for the Tribunal to resolve any differences of opinion between the RMO and IP. IP reports that cannot be tested during oral evidence may be given less weight than those presented in person.

Adjournments

Adjournments are normally to be avoided but are sometimes necessary, for either the preparation or presentation of additional reports. Even so, delay

should be kept to a minimum. Rule 16 (1) permits a Tribunal to adjourn for the purpose of obtaining further information or for such other purposes as it may think appropriate but Judicial Review has decided (1986) that Tribunals are not empowered to adjourn to monitor progress.

The patient

The patient, who may or may not be the applicant, may represent himself. His attendance is not essential. If he does not wish to attend, the Tribunal may agree to exclude him (SI 942, Rule 21 (4)). He may also be excluded for part of the hearing, but his representative must remain. There may be times when it is better that the patient hears the evidence and in these circumstances the Tribunal, if the patient feels under pressure and wishes to absent himself, may temporarily adjourn until he is more composed. When all the evidence has been given the patient, or his representative, is given an opportunity to address the Tribunal.

Even when represented, the patient may feel threatened or dissatisfied with the proceedings, as well as safeguarded by them. Even though he has requested the Tribunal he may be disturbed by even informal proceedings, not quite knowing what he has let himself in for! More positively, as the Tribunal proceeds, the patient may benefit from hearing the pros and cons of his management debated in some detail.

Those patients who are given automatic Tribunals without themselves appealing may feel even more threatened. Peay (1988, 5.2.4 & 7.8 & 1989) confirmed the trauma that the patient can feel on automatic referral and suggest remedies, such as permitting a patient to 'opt out', sitting in absentia, or paper-based assessments.

The nearest relative

The nearest relative in law (NR), or other relatives, may wish to be present subject to the discretion of the Tribunal. Although the NR will have received statutory information about the detention and his own powers, including those of discharge, he may ill understand them. He may also, as a third party, not necessarily be informed of all the facts about the patient. This can call for delicate decisions, usually on the part of the MM, who can know facts that are relevant to the Tribunal's decision, but which are unknown to the NR and may be damaging to the patient if disclosed e.g. facts about illicit drugs, debts, and relationships. If disclosure is essential the Tribunal may have to exercise its right to exclude witnesses while this evidence is heard.

The President

The role of the President, as the legal member, is to guide members and witnesses in matters of law, introduce and explain the proceedings, conduct their progress in an informal manner and ensure fair play to all. He will normally lead in the examination of the patient, followed by the other members. The decision of the Tribunal may be announced by the President at the end of proceedings and he will prepare the written report.

The lay member

The task of the lay member is to contribute in equal share to the Tribunal's decision. The lay member will normally lead the evidence given by the social worker, and take a prime interest in the social circumstances and behavioural aspects of the case. It is recognised that many "lay" members are well qualified professionals in their own right, and their expertise as such is valued, but this is not to diminish the contribution of the truly "lay" lay members. The lay member is often, although not always, instrumental in ensuring that when the applicant is a woman, a woman is also sitting with the Tribunal.

The medical member

The Tribunal medical member (MM) will normally lead in the examination of the report and evidence of the RMO and any independent psychiatrist. He must make sure that all relevant clinical points are brought out in evidence. Although an experienced Tribunalist and knowledgeable in the application of Tribunal law, he will not possess the same weight of first-hand knowledge of the patient as the RMO. Additionally, although an experienced psychiatrist, he may not match the RMO in psychiatric sub-speciality experience (e.g. in forensic psychiatry).

Yet he is in a very responsible position, particularly if there is a conflict of opinion between the RMO and the IP. His lack of personal involvement in therapy will help his objectivity, and his intermediate position between the carers and the lawyers can be to the advantage of both. He will bring his own clinical experience and skills to bear, but most of all he will be able to bring a medical mind to bear on a critical review of the evidence and opinions as presented. To do so effectively he will need to learn the art of gentle cross-examination!

The early release of witnesses

Tribunals recognise that witnesses lead busy professional lives and will give consideration to releasing them after they have given their evidence. This is a compromise, and there are circumstances when it can be extremely valuable to have witnesses present throughout. As the RMO is representing the views of the responsible authority then, under SI 942 Rule 22 (4), he may exercise the authority's right [with others] to hear evidence, put questions and call witnesses. This he clearly cannot do if he has been released.

Decisions and their communication

When all has been said, the witnesses will retire, and the Tribunal members will weigh the evidence and make a decision (discharge, non-discharge, etc), if necessary on a majority vote. They must formulate reasons in law for their decision, and clinically based reasons for holding this view (colloquially the 'reasons for reasons'). The decision is therefore tripartite: decision, legal reason, clinical reason. For example, they may not discharge a patient (decision) because they are not satisfied that he is not suffering from mental illness (reason in law) and not satisfied that it is not necessary for his safety (reason in law) because he is still depressed and suicidal (clinical reason for legal reasons).

Difficult and obscure points of both medicine and law may have to be considered. In marginal cases the 'reasons for reasons', if they are to fulfil the criteria earlier set out, could be considerably longer than quoted here.

The interpretation of 'then' in the Act, which becomes in effect 'now' at the hearing, requires common sense. It would be unrealistic to expect the applicant who is thought to be dangerous to show violence at the actual hearing. Dangerous behaviour a few days earlier may be taken as pertinent to a current decision. As the behaviour to be considered becomes less proximate to the time of the hearing it may be thought to carry less force in the present, but, in this example, deeds of severe violence, may cast a longer shadow than minor indiscretions. The interpretation of 'nature *or* degree' (of illness etc) which warrants detention for treatment is also open to different clinical interpretations and could be further defined.

When the Tribunal's decision is made it must be recorded in writing, with the supporting reasons, signed by the President, and communicated to the patient, and all interested parties, within seven days. Additionally the decision may be, and is often, communicated to the patient by the President immediately after the hearing. There is provision for information that might be detrimental to the patient to be withheld from him, and from other parties. When recommendations are made the Tribunal must specify the period after which they would wish to reconsider the case in the event of the recommendations not being complied with.

Conclusions

Tribunals represent a necessary and important safeguard for a small group of psychiatric patients highly selected for disturbed behaviour, social disadvantage and imposed constraint. For many participants, unless they are a 'high incidence' branch of the service, Tribunals will be a relatively infrequent occurrence. Nevertheless they are time-consuming, intrusive, and professionally demanding. Although neither the system nor its execution are perfect, Tribunals are reasonably fair in conception and operation.

The performance of Tribunals should be no less open to critical review than the services which they examine. At a time when clinical audit is gaining acceptance Tribunals can be seen as 'auditing' the work of RMOs. They themselves should also be audited. If there is to be an examination of practice at any level it is important that it is seen to be a fair critical review, and not as 'criticism'.

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