

Patients' awareness of the mental health tribunal and capacity to make requests

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Aims and method To evaluate patient awareness of the mental health tribunal and identify any association between capacity to request a tribunal and frequency of completed hearings. A cohort of detained patients within a secure hospital were assessed and data for past tribunals evaluated by presence of capacity and mode of application.

Results Of the 65 patients evaluated, 78% were aware of the tribunal's power to discharge, 14% were aware of its power to recommend leave and 4% were aware of its power to recommend transfer; 12% lacked capacity to request a tribunal. Patients with capacity received more completed hearings per year than those without, both overall (0.58 v. 0.29 per year, $P = 0.04$) and by patient application (0.45 v. 0.12 per year, $P = 0.03$).

Clinical implications Hospital managers should ensure that all detained patients have regular assessments of their capacity to request a tribunal and that those who lack capacity are referred to the Secretary of State when it is considered that a tribunal would be in their best interests. Hospital managers should consider referring such cases to the Secretary of State every 12 months.

Declaration of interest None.

Patients detained in hospital under the Mental Health Act 1983 (as amended in 2007) are protected by a range of rights and safeguards. This includes their right under Article 5(4) of the European Convention on Human Rights to take proceedings by which the lawfulness of their detention can be decided speedily by a court and release ordered if detention is not lawful. Within England this is met by the first-tier tribunal (mental health) and governed by the Mental Health Act 1983 and Tribunal Procedure Rules 2008. The tribunal has the power to discharge any detained patient. In the case of a restricted patient the tribunal has no formal power to make recommendations but can make extra statutory recommendations for leave or transfer. For non-restricted patients the tribunal has a formal power to make statutory recommendations for leave or transfer. Cases are automatically referred to the tribunal with additional specified rights of application by patients or their nearest relatives.

The Mental Health Act 1983 requires hospital managers and local Social Services authorities to ensure that patients understand their rights to apply for a tribunal. Although the Mental Capacity Act 2005 contains an overriding principle of assumed capacity, it also provides statutory criteria to determine lack of capacity. Patients who lack capacity to request a tribunal rely on automatic hearings or nearest relative applications. Alternatively, under Section 67 of the Mental Health Act the Secretary of State for Health can refer most non-restricted detained

patients to the tribunal. Although anyone can make such requests to the Health Secretary, the Mental Health Act *Code of Practice* states that hospital managers must consider such referrals in cases of potential Article 5(4) violation and highlights lack of capacity, no previous tribunals, Section 2 extension pending nearest relative displacement and a long period since the last tribunal as reasons for initiating such references.¹ For patients detained under restriction orders, Section 71(2) of the Mental Health Act enables the Secretary of State for Justice to refer at any time a restricted patient to the tribunal.

Past literature on tribunals has concentrated on report preparation^{2–4} as well as procedural, statistical, economic and outcome-related aspects of the tribunal.^{5–10} In terms of capacity and in-patient treatment, Owen *et al*¹¹ found that 60% of patients admitted from the community to acute general adult wards lacked capacity to make decisions on their treatment. Recently, a study of patients' experiences of the first-tier tribunal found that more than two-thirds of patients were supported in making applications by their solicitor, with less than 10% being helped by nursing staff and only a small minority being helped by an advocacy service.¹² To our knowledge, there have been no studies on patients' understanding of the tribunal and ability to access tribunals dependent on capacity to make requests. We present findings from a cross-sectional analysis of patients within a secure setting on both issues and suggest recommendations for clinical practice.

Method

This study was conducted as part of a service evaluation into Mental Health Act administration at St Andrew's Healthcare, Birmingham, and registered with the St Andrew's Healthcare Clinical Audit Team. Given that the study was an audit of adherence to standards within the Mental Health Act *Code of Practice*, ethical approval was not required. During December 2012, N.G. consulted all detained in-patients within the men's medium and low secure wards at the Birmingham hospital, in relation to their rights of appeal which included an assessment of their capacity to request a tribunal using the criteria within the Mental Capacity Act and process described by Church & Watts.¹³ The capacity assessment evaluated initial awareness of the tribunal, its main powers and process for initiating requests. The relevant important information and rights of appeal were then explained with use of appropriate aids as required. A decision was made regarding capacity. Responsible clinicians were advised accordingly if the patient lacked capacity. Demographic and diagnostic information was obtained from patient health records.

Summary statistics for patient awareness and conclusion on capacity were calculated for all patients evaluated. Patients were then grouped by the presence or absence of capacity and details of completed tribunal hearings during the current period of in-patient detention and allocation of solicitor were obtained from the hospital's Mental Health Act office. The hospital opened in March 2009; therefore patients transferred to the hospital who had missing data for previous tribunals were excluded with the assumption that missing data would be evenly distributed between groups. A power calculation was not performed but all available data were used in the analysis. The mean number of completed tribunals per year was calculated with subgroup analysis by mode of tribunal application. Independent *t*-test statistics were calculated (SPSS version 16 for Windows) to examine any associations between capacity and frequency of completed tribunal hearings.

Results

On the whole, 65 patients were assessed. Table 1 outlines the baseline characteristics of the sample including diagnosis, age, ethnicity, Mental Health Act status, initial awareness of the tribunal and methods of requesting hearings. Twenty-three patients were located between 2 medium secure wards and 42 between 3 low secure wards. All patients were male with a mean age of 37 years (range 20–63). All patients were considered to have a disturbance of the mind or brain due to mental disorder. The majority of patients ($n = 57$, 88%) had

Table 1 Patient characteristics and initial awareness of factors relevant to the tribunal ($n = 65$)

Patient characteristics	Patients <i>n</i> (%)
Diagnosis	
Psychosis (schizophrenia/schizoaffective disorder)	65 (100)
Substance misuse	52 (80)
Alcohol misuse	19 (29)
Personality disorder	9 (14)
Sexual deviation	3 (5)
Intellectual disability	2 (3)
Autism spectrum disorder	1 (2)
Hyperkinetic disorder	1 (2)
Ethnicity	
Black	20 (31)
White	28 (43)
Other ethnic minority	17 (26)
Mental Health Act legal status	
Section 3	25 (44)
Section 37	8 (14)
Section 47 (notional 37)	7 (12)
Section 37/41	23 (40)
Section 48/49	1 (2)
Section 47/49	1 (2)
Initial awareness of factors relevant to the tribunal	
Correctly aware of section status	55 (85)
Aware of independent nature of the tribunal	10 (15)
Tribunal's power to discharge	51 (78)
Power to recommend leave	9 (14)
Power to recommend transfer	3 (4)
Patient reports having a solicitor	46 (71) ^a
Aware of solicitor's name/firm	25 (38)
Aware of ability to request a tribunal via solicitor	36 (55)
Request via clinical staff	14 (21)
Request via hospital's Mental Health Act office	1 (2)
Aware of at least one method	45 (69)

a. The Mental Health Act office confirmed 44 (68%) of patients had an active solicitor.

capacity to request a tribunal, of whom 9 (14%) required additional aids consisting of written information in order to achieve capacity. Eight patients (12%) lacked capacity and no additional aids were possible to enable capacity. These patients lacked the ability to understand, retain and weigh up the required information but would have been able to communicate a decision had they been able to reach this point.

When grouped by capacity, 17 patients had missing data for past tribunals, with 16 and 1 being excluded from the capacity and non-capacity groups respectively. Table 2 outlines the results for length of admission and completed tribunal hearings per year by capacity. One patient from the capacity group had a tribunal initiated by their nearest relative which was not included in this analysis. Neither

Table 2 Completed tribunal hearings by capacity and mode of application

	Has capacity to request a tribunal ($n = 41$)	Lacks capacity to request a tribunal ($n = 7$)	Independent <i>t</i> -test <i>d.f.</i> = 46
Length of admission, years: mean (range)	5.27 (0.16–17.55)	5.03 (3.10–10.15)	
Tribunals per year, mean	0.58	0.29	$t = 1.38, P = 0.04$
Patient requests	0.45	0.12	$t = 1.91, P = 0.03$
Automatic requests	0.09	0.17	$t = -1.11, P = 0.88$

group had any tribunals initiated by a reference from the Health Secretary. The restricted patients only had automatic tribunals initiated by the Justice Secretary. Patients who had capacity to request tribunals had more tribunals per year both overall (0.58 *v.* 0.29 per year, $P = 0.04$) and by patient application (0.45 *v.* 0.12 per year, $P = 0.03$). Patients who lacked capacity appeared to have more frequent automatic hearings but this did not reach statistical significance.

Discussion

During recent years, the proportion of patients appealing to the tribunal has continued to increase.^{14–16} Between 2007 and 2008, 9137 tribunal hearings were heard with 17% resulting in discharge,¹⁷ suggesting that tribunals can be effective in pursuing discharge. Past research also highlights that tribunals protect patients against inappropriately long hospital admissions.¹⁸ Patients within secure settings often have complex risk factors and typically require long periods of in-patient treatment making it of fundamental importance that they understand their rights of appeal related to requesting tribunals.

Our finding that 85% of patients were correctly aware of their section status and that 78% knew of the tribunal's power to discharge indicates that during the course of their hospital admission, efforts to ensure that they understand their Section 132 rights of appeal have been successful. Reassuringly, almost 70% of patients knew at least one method of initiating a request for a tribunal. Our finding of limited awareness of the tribunal's power to make recommendations for leave or transfer is concerning but these issues would invariably be considered by the patient's solicitor or the tribunal following an application. However, the possibility that some patients may have missed opportunities to apply for tribunals due to a lack of awareness of these factors remains. Limited awareness of the tribunal's independence raises the possibility that more patients may have appealed if they had better understood this fact.

Capacity is decided on the balance of probabilities yet despite this low threshold in determining its presence, 12% of patients were still found to lack capacity to request a tribunal. Whether such patients lose opportunities to make clinical progress can be debated, since forensic patients are seldom discharged by tribunals.¹⁹ We suggest that tribunals may still offer benefits for these patients, many of whom are far from home and relatively isolated from friends and family. Wood²⁰ highlights that tribunals are valuable in enabling better communication between patients and their clinical teams; perhaps tribunals help focus the clinical team on matters that would otherwise have gone unattended such as community leave, transfer to less secure settings or a hospital closer to the patient's home area. Our finding that patients who lack capacity to request tribunals have fewer completed hearings is not surprising but provides evidence that such patients receive fewer opportunities to benefit from the tribunal process than their more able peers.

We suggest that when patients lack capacity to request a tribunal, in addition to situations cited within the Mental Health Act *Code of Practice*, references should be pursued in

all cases where it is in the best interests of the patient. Factors likely to be considered when determining best interests may include the patient's past or current wishes, lack of community leave, being located far from their home area, significant clinical disagreements on the patient's treatment and difficulty organising aftercare arrangements. In addition, the potential for distress to the patient as a result of having a hearing as well as the views of the patient's family or advocate should be taken into consideration.

Limitations

This study has a number of limitations, the most significant being low numbers in the lack-of-capacity group. Conducting the study among patients within a secure setting suggests the results may not easily generalise to acute in-patient settings. It remains possible that some patients underreported their awareness of the tribunal. Data for past tribunals were considered to be reliable but the possibility of unaccounted tribunals remains. There was a greater proportion of missing data for the group that had capacity introducing possible bias. The study estimated the prevalence of patients who lack capacity within a cohort of detained patients; the incidence is likely to be lower since patients who had capacity are more likely to have requested tribunals and been discharged prior to the study.

Patients who lack capacity to request a tribunal are probably the most vulnerable cohort of detained patients within mental health services and require the highest levels of vigilance in ensuring their rights under the European Convention on Human Rights are observed. We suggest that when advising patients on their rights of appeal, efforts should be made to explain not only the tribunal's power to discharge but also its independence and ability to recommend community leave or transfer. We recommend that the advice within the *Code of Practice* be extended to require hospital managers to ensure that all detained patients have regular assessments of their capacity to request a tribunal and that those who lack capacity to request a tribunal are referred to the Secretary of State when it is considered that a tribunal would be in their best interests. We suggest hospital managers should consider referring such cases to the Secretary of State every 12 months.

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