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Consultant psychiatrists' knowledge of their role as representatives of the responsible authority at mental health review tribunals

AIMS AND METHOD

A postal survey of consultant psychiatrists was carried out to assess their level of knowledge about the role of the person representing the responsible authority at a mental health review tribunal (MHRT).

RESULTS

Consultants generally had a low level of knowledge and understanding of their responsibilities as representatives, which increased since appointment and with experience of MHRTs. They thought it appropriate that they continue representing the detaining authority in most cases, but recognised training needs.

CLINICAL IMPLICATIONS

Postgraduate training and continuing professional development should address the competencies required for the representative role. Trusts should review their practice in respect of legal representation at MHRTs.

Consultant psychiatrists frequently appear before the mental health review tribunal (MHRT) in their capacity as responsible medical officer for patients detained under the Mental Health Act 1983. In addition to giving evidence to the Tribunal, they act in most cases as the representative of the responsible authority, a role that entails significant powers and responsibilities. Although psychiatrists are skilled and experienced at presenting psychiatric opinions, they may be less well prepared for the duties required of them as representatives. Consultants' knowledge of mental health law has generally been shown to be poor, although some studies show better levels of knowledge (Humphreys, 1999; Bhatti *et al*, 1999; Peay *et al*, 2001).

The MHRTs are independent judicial bodies that operate under the provisions of the Mental Health Act 1983. In most Tribunals there are two parties to the legal proceedings: the patient and the responsible authority. The patient is almost invariably legally represented by a solicitor or barrister with experience in mental health law. The responsible authority is usually represented by the responsible medical officer, and legal representation is rare (Coates, 2004).

Neither the Mental Health Act 1983, nor the Mental Health Review Tribunal Rules 1983 contain a clear statement of the rights or responsibilities of the responsible medical officer at MHRTs. Textbooks, which are aimed primarily at legal practitioners (Gostin & Fennell, 1992; Eldergill, 1997; Bartlett & Sandland, 2003), tend to give detailed guidance for lawyers representing patients, but little or none for those representing the authority. This probably reflects the reality of legal practice, where legal representation other than for the patient is extremely rare.

The Royal College of Psychiatrists requires trainee psychiatrists to develop 'knowledge and understanding of the legal and ethical framework of psychiatric practice, including the working of the relevant Mental Health Act [and] the responsibilities of the responsible medical

officer' (Royal College of Psychiatrists, 1998), but specific experience of MHRTs is mentioned only within the recommended experiences for trainees in forensic psychiatry, and no distinction is made between the roles of a witness and a representative at the Tribunal. The need for specific training in this area is increasingly recognised (Naeem *et al*, 2007).

If MHRTs are to make good decisions then it is essential that all relevant evidence is presented and adequately tested. The responsible medical officer is not only a crucial witness of fact and of opinion (Wood, 1998; Lodge, 2005), presenting the justification for continuing detention, but also, as representative of the responsible authority, has an important role in testing the strength of argument and evidence advanced in favour of discharge. The person representing the responsible authority needs to have good knowledge of the Mental Health Act and the MHRT rules, the rules of evidence applicable to the Tribunal's proceedings, the relevant case law and the implications of the Human Rights Act 1998, so as to represent the interests of the authority. The ambiguous position of the medical member of the Tribunal has been much discussed (Richardson & Machin, 2000), but the dual role of the responsible medical officer as both witness and representative, has received scant attention.

The aim of our study was to ascertain the level of knowledge consultant psychiatrists have about their legal rights and duties when acting as representative of the responsible authority at MHRTs. We also wanted to establish whether the level of knowledge varies with length of time as a consultant, experience of MHRT hearings and sub-specialty in psychiatry.

Method

A questionnaire was sent to 210 consultant psychiatrists practising within the Eastern Division of the Royal College of Psychiatrists, identified by the Membership Department of the College (i.e. those consultants who had



agreed to be approached in this way for research purposes). The sample included consultant psychiatrists working in various psychiatric specialties, across eight mental health trusts.

A questionnaire was developed consisting of three sections: section one asked about age, length of experience as a consultant, and area of psychiatric practice; section two related to experience of MHRT hearings, either as responsible medical officer for a detained individual or as a medical member of the MHRT panel. Participants were also asked whether they had experience of attending an MHRT at which the responsible authority had been represented by a solicitor or barrister, whether they felt responsible authorities should arrange such representation, and whether they would find specific training on these issues useful. Section three comprised 12 situations or issues that might arise during an MHRT hearing, each followed by four true/false statements (there was one true statement in each case; see online supplement) about the rights or responsibilities of a representative in that situation.

The questions were reviewed and the wording refined by two experienced mental health lawyers with extensive experience of MHRTs, both as representatives and as legal members of the tribunal. The questionnaire was then piloted with five consultant forensic psychiatrists, and the wording and presentation of the questions further improved.

As an incentive to participate, consultants who returned the questionnaire were entered into a draw for a prize of a textbook of mental health law. A single follow-up letter was sent to non-responders after 2 weeks. The study was approved by the Norwich and Waveney Research Governance Committee and the Norfolk Research Ethics Committee. Research governance approval was subsequently received from the seven other mental health trusts involved in the study.

Data were analysed using SPSS version 13.0 for Windows using non-parametric statistical analysis. Descriptive statistics were used for demographic variables and comparisons made between different variables using Spearman's correlation analysis, Mann-Whitney and Kruskal-Wallis tests, allowing comparisons between median and interquartile ranges and estimation of the *P*-values. Confidence limits for the proportion of correct responses were estimated using an *n*-trial independent Bernoulli model.

Results

Questionnaires were returned by 102 consultants (49.5%; Table 1). Each question in section 3 was left unanswered or marked as 'don't know' by between 10 and 13 participants – these have been treated as incorrect responses in the following analysis.

Of the responses obtained, 537 were correct (43.9%; 95% CI 41.1–46.7%). The proportion of correct answers to individual questions varied between 22.5% and 70.6% (Table 2). The multiple choice format of the questionnaire implies that some of the correct answers

will have been given by consultants who were not fully confident of their answers. Taking the assumption that they would be equally likely to choose any of the four alternatives, an estimate has been made of the proportion of consultants who gave the correct response from knowledge rather than by chance. For example, if 40% of participants gave a correct answer, we estimate that as well as the 60% giving incorrect answers, another 20% had 'guessed correctly'; and that only 20% actually knew the correct answer. This estimate is clearly simplistic: responses reflect varying levels of knowledge between complete certainty and total guesswork, and participants might be able to eliminate some answers as incorrect and choose between the remaining two or three answers with varying degrees of certainty. The estimated proportion of 'known' answers is given only as a general indication of the level of participants' knowledge. However, the low proportion of unanswered questions and the high number of incorrect answers suggest that many participants gave answers about which they were less than certain.

The 93 participants who answered at least one question in section 3 averaged about six correct responses (mean=5.89, median=6, mode=7); 12 participants (13%) scored 3 or less out of 12, a correct response rate consistent with chance; 40 participants (43%) scored 5 or less, a correct response rate of less than half; only 2 participants scored 10 or more, and none scored 12.

Scores increased significantly with length of time since first consultant appointment (Spearman's rank correlation coefficient: $r_s=360$; $n=87$, $P=0.001$).

Table 1. Characteristics of participants (n=102)

Category	Participants n (%)
Years since first consultant appointment	
1–5	24 (24)
6–10	27 (26)
11–15	19 (19)
16–20	13 (13)
> 20	10 (10)
Psychiatric specialty	
General	40 (39)
Old age	24 (24)
Forensic	15 (15)
Child and adolescent	11 (11)
Addiction	4 (4)
Learning disability	3 (3)
Liaison	3 (3)
MHRTs attended per year	
0	15 (15)
1–5	53 (52)
6–10	23 (23)
11–15	4 (4)
> 15	7 (7)
Medical member of MHRT	
Yes	11 (11)
No	88 (86)

MHRT, mental health review tribunal.

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Issue ¹	Percentage of correct answers (95% CI)	Estimate ² of actual percentage of known answers (95% CI)
1. Appointment of representative	41.2 (31.6–50.7)	21.8 (13.8–29.8)
2. Disclosure of reports	70.6 (61.7–79.4)	60.9 (51.4–70.4)
3. Admissibility of independent report	51.0 (41.3–60.7)	34.8 (25.6–44.0)
4. Late submission of report	46.1 (36.4–55.8)	28.3 (19.5–37.0)
5. Cross-examining witness	28.4 (19.7–37.2)	4.8 (0.7–9.0)
6. Appealing against decision	22.5 (14.4–30.7)	–3.0 (–6.0–0.0)
7. Commenting on point of law	26.5 (17.9–35.0)	2.2 (–0.6–5.1)
8. Repeated detention after discharge	62.7 (53.4–72.1)	50.5 (40.7–60.2)
9. Evidence from junior doctor	37.3 (27.9–46.6)	16.5 (9.3–23.8)
10. Challenging patient's evidence	33.3 (24.2–42.5)	11.3 (5.2–17.5)
11. Making a submission	58.8 (49.3–68.4)	45.2 (35.6–54.9)
12. Objecting to panel member	48.0 (38.3–57.7)	30.9 (21.9–39.9)
Total	43.9 (41.1–46.7)	25.2 (22.8–27.6)

1. Each issue corresponds to the question in the questionnaire which addresses it.
2. See text for method of estimation

Although the number of correct responses was greater for those who attended more tribunals per year, this was not statistically significant ($r_s=0.197$; $n=93$, $P=0.059$); the small number of participants who were also medical members of the Tribunal did score significantly higher (Mann–Whitney $U=128.5$, $P<0.001$).

There was a significant association between the total number of correct responses and psychiatric subspecialty (Kruskal–Wallis=18.75, d.f.=6, $P=0.005$), which was largely explained by a greater total score for forensic psychiatrists than other specialties (Mann–Whitney $U=299.0$, $P=0.003$). Differences between other specialties were non-significant.

Twelve of the participants (12%) had experience of attending a tribunal at which the responsible authority had been legally represented; 6 stated (6%) that such legal representation should 'always' be provided, 64 that it should 'sometimes' be provided (63%), and 27 that it should be provided 'rarely' (27%), with only 3 considering (3%) that there should 'never' be legal representation. The majority of respondents ($n=76$, 75%) stated that they would find specific training on these issues useful.

Discussion

Approximately two-thirds of the consultant psychiatrists in the Eastern Division were willing to be contacted, and 49% of those contacted returned questionnaires. The data held by the College do not establish whether or not the consultants willing to be contacted for research purposes are similar in terms of demography or specialty to the wider consultant population, but those responding to this survey were broadly similar to Eastern Division and UK consultant psychiatrists as a whole in terms of specialty. As might be expected given the topic, specialties that might have more involvement with tribunals (general adult, old age, forensic) were slightly overrepresented in our study, and specialties with less involvement (child and adolescent, learning disability,

liaison) were underrepresented. No responses were received from consultant psychotherapists.

There was generally a low level of knowledge about the role and responsibilities associated with representing the responsible authority among the participants – fewer than half the responses given were correct. Only 4 of the 12 questions were answered correctly by more than half the participants and the proportion of those answering correctly did not differ significantly from the 0.25 that would be expected by chance. To their credit, participants recognised the need for further training in this area, with more than three-quarters saying that this would be valuable, and there was little support for employing specialist legal representatives routinely, suggesting that consultants are willing to continue acting as representatives, and see this as an appropriate part of their duties. Nevertheless, 97% of participants believed that legally qualified representation would be desirable on at least some occasions.

When acting as representative of the responsible authority, a consultant psychiatrist has various powers and duties before and during the tribunal. If the interests of the authority are to be adequately protected during these proceedings it is essential that the representative is aware of the nature and scope of their responsibilities. This study suggests that this is rarely the case, and that most consultants are naïve as to the significance of their position as the representative, the scope of their legal powers, or the necessity of actively discharging their legal duties. It is a matter of considerable concern that some consultant psychiatrists do not know the law that relates to their duties and powers in relation to MHRTs: this has important implications for their trust, service users and the public.

Mental health trusts should take more cognisance of the fact that they are frequently a party to legal proceedings at which their interests are represented not by qualified lawyers but by consultant psychiatrists, and that those consultants may have limited knowledge or understanding of their role. If trusts are content for this



situation to continue, they should at a minimum satisfy themselves that psychiatrists tasked with this role are competent to discharge it. It is interesting to note that 12% of our sample had experience of attending an MHRT at which the responsible authority had professional legal representation: it may be that this will be an increasing practice in the future, and that consultant psychiatrists would broadly support such a development.

Psychiatrists acting as representatives in legal proceedings are likely to be held accountable only to the standard expected of a reasonable psychiatrist acting in that role, rather than to be competent to the standard of a legal professional. However, there is a duty on all doctors to practise only within the limits of their competence and experience (General Medical Council, 2006). Psychiatrists considering whether or not to undertake this role must be satisfied that they have the requisite knowledge of MHRT procedure and adversarial skills to discharge the responsibilities adequately. As participants in this study have recognised, this may entail specific training and the development of competencies that have not traditionally been included in psychiatric training programmes.

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Declaration of interest

C.J. is a medical member of the MHRT.

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Psychological therapies provision: views from primary care

AIMS AND METHOD

Recent National Health Service (NHS) policy and guidelines support the increased provision of psychological therapies. As secondary care providers of psychological therapies, we carried out a questionnaire study of how our services were perceived by local general practitioners (GPs). All GPs in the borough of Southwark were included.

RESULTS

General practitioners value secondary care psychotherapeutic input across a spectrum of complex diagnostic groups and are interested in further training/education. They also consistently complain about long waiting times and confusion about accessing the various services.

CLINICAL IMPLICATIONS

With increasing interest in and willingness to fund the delivery of psychological therapies, there is the potential for working more effectively across the primary–secondary care divide. However, improved communication between primary and secondary care is essential if the increased commitment at government level is to be translated into a locally effective service.

The new general practitioners' (GP) contract, as well as the reorganisation of the primary care trusts and the promise of practice-based commissioning have been

influential in redefining the primary–secondary care boundary. From a psychiatric perspective, there is increasing emphasis on the preservation of secondary