Psychiatric Bulletin (1992), **16,** 43–52

Correspondence

Need for review of Tribunal and appeals system

DEAR SIRS

With regard to the numerous letters concerning various aspects of the Mental Health Act recently published I would like to make the following comments:

(a) With reference to Professor Prins' comments (*Psychiatric Bulletin,* 1991, **15,** 640–641) concerning those considered "hopeless" by the Responsible Medical Officer, I must agree with Dr West's point of view (*Psychiatric Bulletin,* 1991, **15,** 641). Having regular Mental Health Review Tribunals, when a patient is quite clearly mentally ill and hospital treatment is essential, is a waste of both time and money in an already hard-pressed health service. Professor Prins adds "to place financial expedience above the protection of such people" etc. I would like to question this point as it is unclear how he is protecting the people and from whom. Most if not all psychiatrists would consider protection of these patients *their* duty and not that of a lay member of a Mental Health Review Tribunal – perhaps Professor Prins feels is he protecting the patients from psychiatrists.

(b) I would like to comment on the letter by Dr Kerry (*Psychiatric Bulletin,* 1991, **15,** 641) that "legal representation may break the mould". In good clinical practice patients are not detained in hospital for longer than is essential for their treatment. Discharge prior to that may well contribute to less than total recovery or control of symptoms and a higher rate of subsequent breakdown. Furthermore, he comments that "the order may be discharged perhaps after a delay" etc. In my view and experience, this is an appalling practice, and may result in patients being discharged after a delay during which time they are not reviewed by the MHRT and may even have deteriorated but must be discharged as per Tribunal instructions. This is hardly fair or appropriate for either patient or doctor. He claims "every patient should have the same right" and this might be true in an ideal world. However, under the current MHA, this is not and cannot be the case. Some groups are discriminated against (particularly those with mental handicap) and this seems set to continue until such time as the current Act is completely reviewed.

(c) I agree with the comments by Dr Azuonye and Dr Campbell (*Psychiatric Bulletin,* 1991, **15,** 577) that the functions and outcome of the changes in the MHA ought to be reviewed. There certainly does seem to be recent research (Joyce *et al* and O'Dwyer *et al* – *Psychiatric Bulletin,* 1991, **15,** 224–226) on the outcome of those detained under the Act; perhaps as Dr West suggests, the role of the independent psychiatrist could be extended so that he either replace the Tribunal system in its entirety or an assessment by the independent psychiatrist of applications for MHRTs be included in order to ensure that while "hopeless" cases are reviewed regularly they may not necessitate stress to the patient or expense to the system of a full MHRT.

I feel that the system of Tribunals and Appeals of those detained under the Act needs a total review and an assessment with regard to its cost effectiveness and alternative methods of appealing against detention orders needs to be considered urgently.

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Mental Health Review Tribunals

DEAR SIRS

We would like to respond briefly to Dr West's comments (*Psychiatric Bulletin,* 1991, **15,** 641) to our original letters (loc cit). Dr West has misunderstood the comment concerning treatment and no further comment is necessary if readers examine Prins' original letter. As to the other points he makes. First, if he does not agree with a reduction in his service budget he should protest in the appropriate place, not expect other budgets to be reduced. Second, any hidden costs should be allowed for in over-all planning (as for example in consultant contracts). Third, for the reasons given in our earlier letters we were dismayed to find Dr West describing

his reluctance to prepare for and attend 'another "hopeless" Tribunal'.

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Use and abuse of Section 4/Section 2, Mental Health Act 1983

DEAR SIRS

The Mental Health Act Commission and Code of Practice are quite specific that Section 4 should only be used in an emergency, and that Section 2 must be used, as far as possible, to admit patients who need such admission. This, of course, is reasonable and rational. However, the other side of the coin is that Section 2 could be mis-used and in certain circumstances Section 4 is appropriate and desirable rather than Section 2. This is valid in cases of "mental impairment" rather than "mental illness" as both conditions come under "mental disorder" in Mental Health Act 1983. This distinction is important as mental illness, particularly in its acute form, is amenable to chemotherapy and can be rapidly controlled, whereas mental impairment may or may not be amenable to medication, particularly the severe behaviour problems which would require time and different therapies, like behaviour therapy and counselling, to get effective control.

May I quote my experience in one situation where an approved Social Worker was insisting at about midnight that a patient was severely disturbed and that she must be admitted only on Section 2 and, therefore, the second doctor must visit to see the patient to implement this Section. I had to point out that this appears to be an emergency, that Section 4 is valid in this case as the second doctor is only 'on call', and not the regular doctor, and that as soon as the patient is admitted Section 4 will be reviewed and appropriate changes, and if necessary Section 2 implemented. The ASW was not happy with this explanation and found another second doctor to complete and implement the Section 2 requirement. The day after admission when I saw the patient I could find no evidence of mental illness or dangerousness on the part of the patient who was willing to stay in hospital voluntarily, and settled down well in the ward. Moreover, psychotropic medication was not necessary. I discovered the motive for admission was not a genuine emergency, but a social reason. If this patient had been admitted on Section 4, there would have been no reason to use Section 2. The legal means of admissions should be flexible enough for the doctors and ASWs to use the appropriate sections of the Mental Health Act.

The Mental Health Act Commission may like to comment about these occasional difficult situations which may lead to unnecessary friction between professional colleagues and detrimental patient care.

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References

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Fitness to appeal

DEAR SIRS

During a recent visit of Mental Health Act Commissioners, a Hospital Manager complained about the large number of appeals by patients against their detention under the Mental Health Act, and asked whether it would be possible to "... do something about reducing the number of appeals required to be heard." The Commissioners were sympathetic but unimpressed. All patients liable to be detained, they advised, had the right to appeal against their detention, even if it was obvious that they had no idea what they were doing.

In the past year, when I have asked patients why they had appealed against their detention, many of them were too psychotic to understand what the appeal was about, let alone put together a coherent reason for appealing – even on the day of the hearing! One Hospital Manager told me how, within minutes of several hearings, the Managers have asked for the patient to be returned immediately to the wards on account of their behaviour.

These experiences argue strongly for the introduction of 'fitness to appeal' criteria which would determine whether a patient is fit to appear before the Hospital Managers or a Mental Health Review Tribunal, and understands what the appeal is about, is able to instruct his legal advisers (if applicable), and can apsychotically challenge the evidence of the Responsible Medical Officer (RMO) or the Approved Social Worker. This would help to filter out – without prejudice to the patients' civil rights – those too disturbed to appear as well as those too psychotic to understand the transactions or marshal meaningful arguments against their detention.

I would suggest that the assessment of a patient's fitness to appeal should not be carried out by his RMO, since the RMO is an interested party. This could be work for an approved doctor not associated with the hospital (and not involved in the original