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Mental health review tribunal medical reports

Khalida Ismail, Shubulade Smith and Tony Maden

Aims and method Medical reports submitted to mental health review tribunals should be of a clinically acceptable standard. We examined 100 medical reports to assess whether they stated the four criteria for detention under Section 3 of the Mental Health Act 1983. We compared the standard of reports according to the seniority, qualifications and speciality of the doctor, and with the outcome from the tribunal.

Results The majority of the reports were written by junior doctors and did not fulfil the criteria laid down by the Mental Health Act 1983. Consultant and forensic psychiatry status were associated with completed reports.

Clinical implications This study was performed in one hospital only but highlights the ongoing need to review and improve the workings of the Mental Health Act before reform is considered.

The introduction of the Community Care Act 1990 and subsequent inquiries into homicides by psychiatric patients, such as the Clunis Inquiry (North East and South East Thames Regional Health Authority, 1994), have led to concerns about the operation of the Mental Health Act (MHA) 1983 (Crimlisk & Phelan, 1996). There have been calls for its reform, especially in the workings of the mental health review tribunal (MHRT) (Blom-Cooper *et al*, 1995, 1996). In Section 72 of the MHA 1983,

https://doi.org/10.1192/pb.22.10.615 Published online by Cambridge University Press

one of the main powers of the MHRT is to direct whether a patient should continue with a detention under the MHA 1983. The MHRT must discharge the section if: (a) the patient is not suffering from a mental disorder requiring treatment or detention or (b) it is not necessary to detain the patient in hospital in the interests of his health or safety or for the protection of others. This decision is based on written and oral evidence from the responsible medical officer (RMO), the patient and his social worker.

Shortcomings in the process of the MHRT which have already been identified include factors related to delays in hearing appeals (Blumenthal & Wessely, 1994); downgrading the index offence in forensic cases (Peay, 1989) and lack of training of the tribunal members in the assessment of risk (Blom-Cooper *et al*, 1996). While these, and other aspects of the MHRT, have been extensively scrutinised (Peay, 1989), the quality of the medical evidence submitted to the MHRT has been less studied. The medical report is a principal source of evidence and is heavily relied upon by the MHRT. The purpose of the medical report is to provide a detailed relevant summary of the patient's history and the criteria for continuing detention. The standard of these medical reports and their impact on the MHRT's function has not been previously examined. It is appropriate that prior to any reform of the MHA 1983, this aspect of the MHRT process should also be scrutinised. We aim to examine whether medical reports state the criteria for continuing detention and whether the standard of the reports is associated with the MHRT's decision.

The study

We reviewed 100 consecutive reports to the MHRT sitting at an inner-London psychiatric hospital reviewing applications against detention under Section 3, MHA 1983. The reports were those held in the hospital's MHA office for the period September 1993 to March 1995. Each report was rated according to whether the following questions, based on the criteria for detention under Section 3 MHA 1983, were answered:

(a) Is the patient suffering from a mental disorder?
(b) If so, what is the form of the mental disorder according to the criteria in the Act?
(c) Is the mental disorder of such a nature and degree that it requires the patient's detention in hospital for treatment?
(d) Is detention necessary for the health or safety of the patient or the safety of others?

Reports which stated all four criteria were defined as complete. The doctors were rated according to three criteria: first, seniority of the doctor (senior house officer/registrar, senior registrar, consultant); second, whether the doctor had gained the membership of the Royal College of Psychiatrists, as evidence of having reached a clinically competent professional standard; third, all doctors who were senior registrar or consultant were further categorised as to whether he/she was also a specialist in forensic psychiatry. The outcome was whether the MHRT decided to discharge Section 3 from the patient.

Findings

Twenty-four per cent of reports stated all four criteria for detention, the median number of criteria stated was two. Fifty-four per cent of reports were prepared by senior house officers/ registrars, while senior doctors and consultants wrote 26 and 20% of reports respectively. Thirty-three per cent of patients who appealed and attended a MHRT were successful in being discharged from Section 3.

The standard of reports in relation to the level of seniority, training, forensic sub-speciality and outcome is shown in Table 1. There was a significant association between seniority and the proportion of complete reports, with consultants three times more likely to submit complete reports than junior doctors (P=0.0139). Doctors with the MRCPsych qualification were twice as likely to submit complete reports. Although this association was not significant (P=0.067) and the lower limit of the confidence interval crossed unity, the upper limit reported a six-fold increased likelihood in the proportion of complete reports. Senior registrars and consultants specialising in forensic psychiatry were nearly eight times more likely to submit completed reports compared with senior registrars and consultants in general psychiatry (P=0.003), but the confidence interval was wide. There was no significant association between incomplete reports and being discharged from Section 3 (P=0.968).

Comment

This is the first study to examine whether MHRT reports are written in accordance with the MHA 1983. This study found that medical reports are written mainly by junior doctors. Only one-quarter of the reports were complete and this made no difference to the MHRT's decision to discharge. The MHA Code of Practice (Code of Practice, MHA 1983) does not specifically recommend that the RMO should write the reports

https://doi.org/10.1192/pb.22.10.615 Published online by Cambridge University Press

Table 1. Association between standard of medical reports and seniority, possession of MRCPsych, forensic specialist status and outcome

	Number of complete reports	Number of incomplete reports	Odds ratio	95% Confidence interval
Seniority				
Consultant	9	11	3.55*	1.25–10.08
Junior doctor[1]	15	65		
MRCPsych qualified				
Yes	15	31	2.42	0.94–6.22
No	9	45		
Forensic specialist[2]				
Yes	8	4	7.71**	1.87–31.7
No	7	27		
Outcome from MHRT				
Section 3 discharged	8	25	0.98	0.37–2.60
Section 3 not discharged	16	51		

1. Junior doctor=senior registrar, registrar and senior house officer.
2. Comparison is for senior registrars and consultants only.
*P<0.05; **P<0.005.

or supervise the preparation of the reports by his/her junior doctors. This questions where the medical evidence comes from. Points not made in the written report would normally be established by oral evidence from the RMO at the MHRT hearing but whether this is, in fact, the case is not known.

Possession of the MRCPsych was not associated with a significant improvement in the standard of the reports. Although the MRCPsych examination is not evidence of training in the MHA 1983, it is evidence that a clinically acceptable standard has been attained and this includes a basic understanding of the workings of the MHA 1983. On the other hand, training in forensic psychiatry does improve the proportion of completed reports, although the variation in this estimate was wide. This suggests that a more intensive training than is currently available in general psychiatry training could improve the standard of medical reports. The comparison between forensic psychiatrists and general psychiatrists was between senior registrars and consultants which emphasises that intensive training is as important as seniority.

A recent audit of medical reports for MHRTs demonstrated that specific training does indeed improve standard of the report (Davison & Perz de Albeniz, 1997). Protocols laying out the responsibility of the RMO have been described and could easily be adapted from the MHA 1983 into clinical training programmes (Brockman, 1993). Whether there is a need to include guidelines in the writing of MHRT reports in the MHA 1983 Code of Practice warrants further debate.

One of the limitations of this study is that this sample of reports was derived from only one hospital and this may not reflect national patterns. The results of this study cannot be generalised to reports pertaining to other sections of the MHA 1983 as the latter were not examined.

In summary, large numbers of medical reports in this hospital were not of the standard required for a MHRT. It is the clinical duty of the RMO to demonstrate sound judgement in a medical report. An effective tribunal system depends on the medical team ensuring that this duty is performed to an acceptable standard. Future research should aim to replicate whether our findings are also present in other hospitals. There is a need for better training and supervision in mental health law, and in the writing of reports by junior doctors. Training can improve the standard of reports. Calls for reform of the MHA 1983 seem premature while existing legislation is not being properly used.

Acknowledgements

We thank Ms Barbara Chaffey and Ms Julie Johnston from the Mental Health Act Office, Maudsley Hospital for their kind assistance.

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Provision for people with anxiety disorder by a community health care trust

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Aims and method Provision for patients with loosely defined anxiety disorders has been reviewed. During a two-week period, 66 of the 69 adult mental health practitioners working in a modestly sized community health care trust surveyed all patients with anxiety disorder currently under their care.

Results These practitioners were seeing a total of 758 patients who fitted a loose definition of anxiety disorder. A further 134 patients had been treated in anxiety management groups during the preceding year. Disparate treatments were being used, reflecting idiosyncratic approaches to this otherwise homeogenous group of patients.

Clinical implications Less than one-tenth of the estimated population of anxiety disorder patients were receiving specialised treatment. Among those that were, choices of treatment were arbitrarily determined and idiosyncratic. It was clear that the management of these patients does not fulfill the requirements of 'evidence-based practice'.

Recent population-based surveys of psychiatric morbidity (Meltzer *et al*, 1995) and of the provision of care (Commander *et al*, 1997) re-emphasise established views: that there is widespread morbidity and only a small proportion of it is addressed by practitioners with specialised expertise in this area. Anxiety disorders make a prominent contribution to the sum of psychiatric morbidity. They are common, disabling and not infrequently complicated by the secondary development of other conditions such as substance dependency or depression. Furthermore, they make a considerable contribution to burdens of care upon primary and secondary health services and it has been shown that investment in improving services for patients with panic disorder is economically fruitful (Salvador-Carulla *et al*, 1995). Against this background we have reviewed one service's provision for people with anxiety disorder in the course of considering how it might be improved.

The study

Central Nottinghamshire Health Care Trust (CNHCT) is the main provider of psychiatric services across Central Nottinghamshire. The catchment includes a relatively densely populated industrial area, redundant mining villages, an affluent residential centre and farming countryside. Services are divided into four fully integrated teams, each responsible for a sector and working closely with their own consultant psychiatrists. Teams have their own consulting facilities in Mansfield, Sutton-in-Ashfield, Ollerton and Newark-upon-Trent. There are

Psychiatric Bulletin (1998), **22**, 618–621

https://doi.org/10.1192/pb.22.10.615 Published online by Cambridge University Press