

Improvements to the Mental Health Review Tribunal service are long overdue

Reforming the appeals process

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When patients in England and Wales (Scotland and Northern Ireland have their own mental health legislation) are detained for assessment and or treatment under the Mental Health Act, they are given protection against wrongful detention through appeal to the Mental Health Review Tribunal (MHRT) service, or the hospital managers, against their continuing detention. The MHRT service will remain unaltered by the Mental Health Act Amending Bill, which commenced the parliamentary process towards enactment on 16 November, 2006.

Currently, approximately 40,000 patients per year are detained under the Mental Health Act, and almost 22,000 appeals are made to the MHRT, of which 12,000 are heard, in 600-plus locations. The appeals for patients who are detained for assessment and treatment – an order that lasts 28 days – have to be heard within seven days. Appeals lodged by patients who are on a civil treatment order should be heard within six to eight weeks. Appeals lodged by patients subject to court orders should be heard within 12 to 16 weeks.

When the MHRT was set up there were only 3,000 appeals per year (1984); the system, despite numerous reorganisations, is today widely acknowledged to be unable to cope adequately with the increased level of demand. This has led to appeal hearings being cancelled or delayed, often at short notice, which is very upsetting to patients and costly to the appeals system. Moreover, there is an approximate 46% fall-out rate when appeals are withdrawn or cancelled because patients are taken off section before the appeal hearing. Current poor communication between hospital clinical teams and Mental Health Act administrators (MHAA) and, in turn, poor communication between the MHAA and the Tribunal secretariat, means that, in many cases, preparatory work is conducted and panels are convened

unnecessarily because late withdrawals or discharge of sections are not confirmed soon enough.

Many of the appeals withdrawals occur within one, two and three days of the scheduled hearing. For example, in the three months October–December 2005, 90 out of 1500 appeals that did not proceed to a hearing were cancelled on the day of the hearing, meaning that a panel was convened unnecessarily. In these cases completion of paperwork and speedy communication is required to avoid MHRT panels turning up needlessly. The average cost of panels is £2,200, including travelling expenses, indicating that the reduction of current ‘wasted’ panels should be a higher priority.

Pilot study

In preparation for the amendment of the Mental Health Act 1983, the Department of Health requested that NIMHE/CSIP undertake a brief pilot study to look at the day-to-day working of the administration of the MHRT between providers of acute inpatient care from the NHS, independent hospitals and the Mental Health Review Tribunal. The aims included identification of good practice from areas where this interface worked well and gaining an understanding of why there are variations in the effectiveness of the administration. In particular, the study looked at reasons for ‘change of date requests’ and ‘on the day adjournments’. Figures from the MHRT (see tables) indicate an unacceptably high proportion of adjournments on the day of the hearing, and a large number of change of date requests (CDRs). These increase costs, impact on clinical staff workloads, and are a cause of concern and uncertainty to patients and their carers. Moreover, there appeared to be significant variations in the system.

A total of eight provider organisations (between them responsible for approximately 27 hospital sites where patients may be detained under the Mental Health Act

1983) participated in a brief service improvement pilot between April and May 2006, involving the monitoring of MHRT unrestricted appeals. A further 25 providers participated in a telephone survey. They included 23 NHS mental health trusts and two independent hospitals.

The findings and recommendations can be grouped under four categories: communication, booking, reports, and miscellaneous.

Communication

The study confirmed a lack of communication between clinical teams and MHA administration about discharge plans for patients awaiting an MHRT hearing, and significant communication problems between hospitals and the MHRT Secretariat, and vice versa.

There seems to be little to no communication between clinical teams and the MHAA on the likelihood of a patient being discharged prior to their appeal hearing taking place. The discharge of patients from section is not a decision that is taken overnight and, where plans for discharge or consideration of discharge are being made, the MHAA should be advised. The MHAA should in turn advise the MHRT Secretariat as soon as possible, to ensure that panels are not unnecessarily booked for appeals that are unlikely to happen until one week in advance. This would free up the availability of panels for hearings that will definitely take place.

Too much time is currently being spent on appeals that will not reach the hearing. Hospital clinical teams could help to improve this position by providing some form of classification for patients appealing against their detention to indicate the likelihood of them still being detained by the time their appeal is heard. Leeds Mental Health Trust is currently carrying out a pilot where clinicians will be asked to submit a patient classification to indicate the likelihood of a patient who lodges an appeal still being detained at the time of the hearing. It is important to stress that this will in no way affect the scheduling of the hearing, but will avoid the early booking of panel members for appeals that are least likely to take place, thus freeing up more panel members for appeals that will definitely be heard.

Currently when patients are discharged from section under section 23 there is no statutory requirement to complete the relevant form, which is therefore very often not filled out at the time of discharge. The MHRT is not able to cancel a hearing until they have a copy of the discharge form, and this often leads to panel members turning up to find that the patient is no longer detained. Last, but by no means least, is the failure to make more use of IT in the transfer of reports and communications. The transfer of reports by IT is far more secure and timely than by mail. Communications would also be enhanced and could be better audited if e-mail was used.

Bookings

Booking of RMOs for MHRT hearings is more difficult than it should be. Many MHAAAs have to ascertain RMOs' availability through their medical secretary, who in some cases is unable to confirm their availability without contacting them. In one trust, the MHAA had their doctors' availability on a wall chart, which was updated regularly. This enabled the MHAA to confirm dates immediately. Trusts need to ensure that their

Table 1: Reasons for 'on the day adjournments'

Report related	49	45%
No report	17	15%
No CPA	11	10%
CPA/Report problem	21	20%
Attendance problems	53	49%
Patient non-attendance	17	15%
No RMO/doctor	14	13%
No solicitor	12	11%
No social worker	4	4%
No panel member	4	4%
No interpreter	2	2%
Miscellaneous	6	5%
Total	108	100%

Table 2: Change of date requests

Change of date requests October to December 2005

October 2005			November 2005			December 2005		
Total	Hospital	Solicitor	Total	Hospital	Solicitor	Total	Hospital	Solicitor
207	163	44	148	120	28	162	136	26

Change of date requests after 48 hours October to December 2005

October 2005			November 2005			December 2005		
Total	Hospital	Solicitor	Total	Hospital	Solicitor	Total	Hospital	Solicitor
33	15	18	18	8	10	10	7	3

RMOs provide and regularly update information about their availability to the MHAA office. The restricted access to consultants' diaries needs to be resolved by trusts' medical or clinical directors.

Bookings for appeal hearings are currently bedevilled by change of date requests. These could be avoided by hospital MHA administrators co-ordinating bookings with the RMO, solicitor, approved mental health practitioner or author of the social circumstances report and, where applicable, the named nurse. This would greatly reduce the number of CDRs currently required when the MHRT finds that the solicitor is unable to make the date initially offered by the clinical team.

Reports

The pilot study found that 73% of reports were delayed by an average of 13 days, and there is little doubt that this often leads to delays and adjournments. The submission of reports needs to be monitored at board level and urgent action needs to be taken to ensure compliance with the Tribunal rules. Some work is being conducted by CSIP in partnership with various agencies, including Communication for Health, to enable the automatic compilation of key elements required for MHRT reports.

Some RMOs and social workers are not responding quickly enough to the requirement for them to provide reports within the three-week time limit required by →

- the regulations. All MHAAAs should send reminders to the relevant professionals at the end of week one, and follow up with further reminders at the end of week two, and then on a daily basis. Directions from the MHRT

Summary of recommendations

No on-cost

- Ensure ethnic monitoring of appeals and their outcomes
- Adoption of IT communication between provider units and the MHRT Secretariat
- Transfer of reports through IT providing a financial saving to provider units in printing/copying and postage costs
- Reference numbers to be applied to all appeals
- MHRT Secretariat to have teams that see the process through from start to finish
- Booking system to be introduced for RMO availability for MHRT hearings
- Communication to be improved between clinical teams and MHAA.

Some on-cost

- MHAA to co-ordinate availability of RMO, solicitor and approved mental health practitioner for hearings, and offer them to MHRT
- MHRT to set standards of accommodation required for hearings and give four years notice for compliance
- Training and guidance on report writing to be provided for clinical staff
- Introduction of a form for patient classification on appeal
- Communication to be improved between MHRT Secretariat and stakeholders.

regional office to clinicians should be copied to trust chief executives, to ensure that this matter is taken seriously. The MHAA must ensure that they report MHRT appeals to their hospital managers and the trust/unit management on at least a six-monthly basis, and include details of the timely provision of reports for the MHRT. Better compliance needs urgent consideration and action by a trust board member with responsibility for the Mental Health Act.

Miscellaneous

There is currently no ethnic monitoring undertaken by the MHRT. A system is currently being tested by Leicestershire Mental Health Trust so that this can be rolled out nationally by the middle of this year. In addition, the MHRT needs to provide a minimum standard of accommodation required for hearings so that hospitals and trusts are able to plan to meet the standards set. Both the MHRT Secretariat staff and the Mental Health Act staff in some hospitals need a greater investment in training to enable them to carry out their duties more competently and with greater confidence.

Implementation

A summary of the main recommendations, identifying those that carry no additional costs and those requiring some additional investment, is given (left). These recommendations will be trialled through PDSA (plan, do, study, act) cycles, to ensure the benefits anticipated from them can be achieved in practice. ■

The full report can be downloaded free from the London Development Centre website at www.londondevelopmentcentre.org

Implementing the Bill

The MHRT work forms part of preparations for the implementation of the Mental Health Amendment Bill. A national plan to support implementation of the Bill has been developed by the Care Services Improvement Partnership (CSIP)/National Institute for Mental Health in England (NIMHE), in consultation with service users, carers, mental health staff and NHS, local authority and other organisations that will be directly affected by the changes.

The plan will put in place local measures needed to ensure that all provisions of the legislation, regulations, Codes of Practice and associated guidance introduced under the Bill are implemented appropriately by statutory, independent and voluntary organisations and their staff with responsibilities under the amended legislation.

Responsibility for leading and co-ordinating implementation of the plan will lie with local implementation leads based in each CSIP/NIMHE regional development centre (although, once enacted, the statutory obligations detailed in the amended Act will be the responsibility of individual local statutory commissioners and providers of services). In addition, CSIP/NIMHE is working nationally on the development of a number of workstreams associated with the amended legislation. These are workforce, Mental Health Act administration, supervised community treatment, training the trainers, and developing a programme to support advocacy. Details of the leads are given (right).

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