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Discussion Paper

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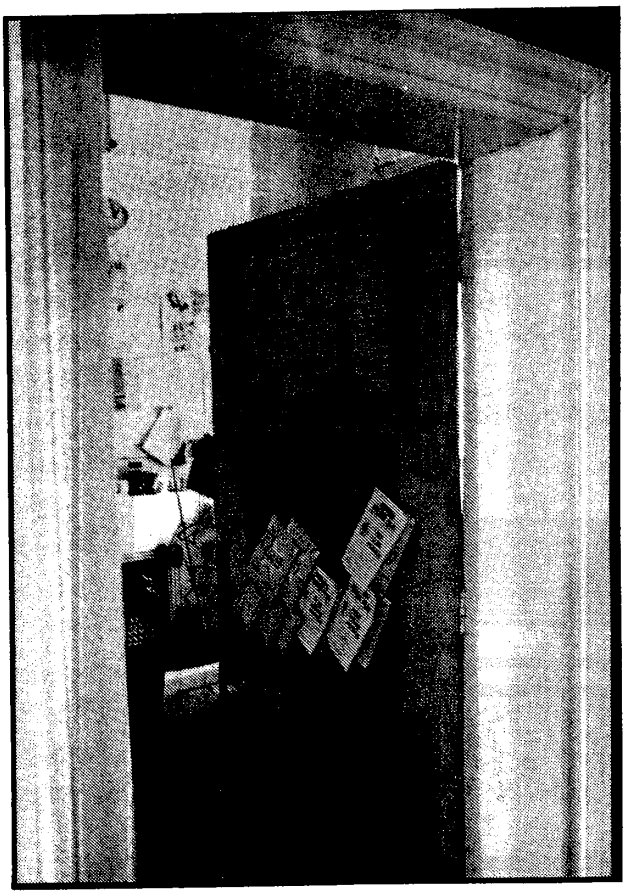
Representation before the Mental Health Review Tribunal:



The Advice and Legal Representation Project at Springfield Hospital, 1985

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INTRODUCTION

The Advice and Legal Representation Project at Springfield Hospital started work in February 1982 with a grant from the King's Fund Centre. It was the first legal and advice service for mentally ill people to be based in a psychiatric hospital. The Project offers a free and independent service to clients within the hospital.

Helen Snell, a Project Worker, undertook a study of the Projects Work with Mental Health Review Tribunals, aided by a further grant from the King's Fund. The discussion document provides a comprehensive introduction to the different aspects of the Tribunal. Using the evidence from her study, Helen Snell argues strongly for independent representation for people appearing before Tribunals, if they are to receive a fair hearing.

It is hoped that the discussion document will provide useful guidance for those wishing to establish a similar service elsewhere. It will also serve as a valuable reference for information on the aims and processes of Mental Health Review Tribunals.

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* The Project itself is written up in King's Fund Project Paper No. 59, "The advice and legal representation project at Springfield Hospital 1982 - 1985: An evaluation" Price £4

ABBREVIATIONS AND DEFINITIONS

ALRP -	the Advice and Legal Representation Project at Springfield Hospital.
MHRT -	the Mental Health Review Tribunal.
The Act -	the Mental Health Act (1983).
MHA -	the Mental Health Act (and schedules).
The Rules -	Mental Health Review Tribunal Rules 1983.
Responsible Authority -	the hospital managers of the establishment where the patient is detained.
Restriction order -	an order made by a court in accordance with S.41 of the Act. It has the effect of requiring the consent of the Home Secretary before the RMO or hospital managers can discharge a patient. A discharge order can be made by an MHRT.
Responsible Medical Officer -	the registered medical practitioner in charge of the treatment of the patient - usually a consultant psychiatrist.

INTRODUCTION

The Advice and Legal Representation Project at Springfield Hospital has offered representation to applicants to the Mental Health Review Tribunal since the Project opened its doors in February 1982. Springfield Hospital is unique in that patients may be legally represented before the Tribunal by a Project worker who will closely examine and question the opinion of the Responsible Medical Officer in the case but who is nevertheless, in the words of a member of the medical staff, 'a guest in the hospital'.[1] By permitting the Project to work within the Hospital, the Health Authority and the Hospital Medical Committee demonstrated their commitment to patient care and, at the same time, allowed the status quo within the hospital to face unprecedented challenge. Representation before the M.H.R.T. has been the most problematic area in the relationship between hospital and Project - one (medical) staff member saw Mental Health Review Tribunal proceedings as something akin to a duel fought to the death.[2] The Project Management Committee considered a request by the Medical Committee that representation at Tribunals by Project Staff be discontinued, but after much debate it was decided that this was an integral part of the Project's work and should continue. Reviewing the situation the Management Committee proposed that in the more sensitive MHRT cases an outside counsel would be instructed, (with the agreement of the client), which would mean Project workers preparing the brief. In some cases, of course, clients elect to instruct their own solicitors and there are some applicants to the Tribunal who choose not to approach the Project at all.

THE STUDY

This paper is the result of a wish to examine the problems caused by representation at MHRTs by Project workers. It involves an examination of MHRTs heard at Springfield Hospital between 1 February 1985 and 31 January 1986 where the ALRP represented the applicant or briefed their counsel. Springfield Hospital is within the jurisdiction of the South West Region of the Mental Health Review Tribunal. Tribunal personnel were interviewed as were applicants to the Tribunal - both those represented by Project workers and those represented by solicitors based outside of the hospital and by barristers. Members of the medical staff at Springfield, current members of staff at the ALRP and solicitors (who regularly accept referrals from the Project) were also interviewed for the purposes of this paper. The paper is in three parts: the Mental Health Review Tribunal; MHRTs at Springfield Hospital in between 1.2.85 and 31.1.86; conclusions.

THE MENTAL HEALTH REVIEW TRIBUNAL

MHRTs are the only tribunals which deal directly with individual liberty. They have, in the words of Prof. Sir John Wood, 'represented since the Mental Health Act 1959, the impact of legal challenge upon one aspect of medical discretion - the right to detain.'[3] He goes on to describe the 'dual perception of the role of the Tribunal - a review of the need for detention made by an independent group of mixed disciplines'[4] with many of the characteristics of a court although with a different function - investigatory, as opposed to adversarial. The opposing view of which Sir John shows less approval, is where the adversarial aspect of the Tribunal is stressed - 'with the patient cast in the role of complainant (plaintiff) and the detaining authority (the hospital) as the defendant. The Responsible Medical Officer becomes, or resembles, a party to the proceedings'.[5]

There exists a very powerful lobby, which has the undoubted support of the psychiatric establishment that the mental health field is one of the least appropriate to formalistic approaches and certainly Prof. Sir John Wood is of the view that the investigatory model predominates.

The development of the MHRT can be seen as growing out of the 'therapeutic optimism' of the 1950s; culminating in the Mental Health Act of 1959 which represented a final departure from legalism in compulsory admission procedures, though some can trace this shift over a century or more. In his dissertation,[6] David Mawson notes that the Percy Commission (1957)[7] favoured the medical view that doctors 'need freedom from legal encumbrances on the admission procedure in order to be able to help the patient at the earliest possible stage'. As a result, 'the medical profession was given an autonomy that was out of proportion to the weight of evidence given by the profession itself'[8] and a wide discretion in a sea of vague definitions, criteria and concepts 'in the interests of (the patient's) health and safety'. The opening paragraph of the Commission's report stated that 'disorders of the mind are illnesses which need medical attention' which, according to Philip Bean,[9] provided the necessary ideological basis for the shift in legislative terms, resulting in the 1959 Act.[10] The initial pronouncement of the Royal Commission - if it can be seen as a statement of intent - permitted the formulation of what Bean termed 'therapeutic legal rules which' (in the Mental Health Act) 'are there to help to refashion human conduct by medical manipulation. The doctor is there to get society's work done and legal rules are used to this

end. It is important to emphasise the point that psychiatrists have power which is considerably greater than that given to almost any other occupational group'.

Bean outlined the properties of these therapeutic legal rules, they are loosely formulated and there are no secondary rules which can inhibit professional decisions, no guidelines as to how they can gather and use information about a patient, save for the requirement that they regard the patient as 'suffering from mental disorder of a nature or degree which warrants his/her detention in hospital' ... etc. Other properties include the fact that the patient is stripped of the usual legal rights, e.g. there is no caution; no reasons are required from the medical profession as to how they arrived at a particular decision. Furthermore, the whole procedure for compulsory admission is conducted away from general public scrutiny. Thus a new group of control agents have been created who 'by using the language of therapy have acquired immense power ... In other words therapeutic legal rules produce therapeutic policemen who detain people in therapeutic jails'.[11] Fennell[12] points to the lack of certainty and the generality of legal definitions of mental illness and disorder, giving as an example the concept of 'necessity in the interests of the patients' health and safety or for the protection of others'. The question is posed, protection of what from what? This lack of certainty produces differing standards of psychiatric practice. Philip Bean[13] found that a variety of factors bear upon psychiatrists when deciding to compulsorily admit someone - not all of them strictly medical. Nevertheless, the justification for giving the psychiatric profession powers of compulsory admission to hospital was that the psychiatrist possesses the necessary expertise and integrity to make a decision as to whether or not a person should be detained.

Fennell[14] notes that the psychiatrist is 'viewed as a scientist performing a diagnostic operation', but that this view obscures essential features in the process, not least the external pressures placed on psychiatrists who must take heed of political or policy-oriented considerations when deciding to admit. Thus rule enforcement - or compulsory admission to hospital - under the Mental Health Act 1959 was based upon certain assumptions about the integrity of the enforcers (i.e. psychiatrists) about what constitutes a 'mental disorder' and about moral concepts such as 'needs' and 'interests'.

It has been said that the law has failed to improve the lot of the mental patient[15] - both the 1959 and the 1983 Acts are 'examples of psychiatrists hegemony in the diagnosis and management of mental illness'. No justification is required for any action by a psychiatrist relating to the compulsory admission of a patient. The only safeguard for the patient - and this is still the case under the 1983 Act - is the setting up of an independent review tribunal after the findings of the Royal (Percy) Commission, which will consider the patient's condition at the time of the hearing and decide whether or not further detention is appropriate. The (MHRT) did not then - nor does it now - safeguard against improper admission under compulsory powers.

Structure and Administration of MHRT's

In 'Mental Health Law' Brenda Hoggett says that MHRTs have many advantages over courts in the provision of a safeguard against compulsory detention. For example, membership can be tailored to the particular problem 'not stuck in the adversarial model of British court procedure, and can adopt elements of the inquisitorial approach'.[16] The difficulty, though, lies in attaining the balance between the apparently overwhelming evidence of the responsible authority and the requirements of natural justice.[17]

Under S.65(1) of the Mental Health Act 1983 there must be established a Mental Health Review Tribunal for each of the regional health authorities in England and Wales. The tribunal's duties may be performed by at least three members - one legal, one medical and one lay member. Responsibility for appointing members of a tribunal for a particular hearing rests with the chairman of the tribunal or another member appointed by him.

Legal members are appointed by the Lord Chancellor and one Legal member of each region becomes regional chairman. The legal member is president of that tribunal and has wide discretion in the conduct of the proceedings. In the case of a restricted patient, the legal member must be drawn from a panel approved by the Lord Chancellor to hear such cases, and must have substantial judicial experience in the criminal courts.[18] Medical and lay members are appointed by the Lord Chancellor both after consultation with the Secretary of State for Social Services (Sched 2, Para 1). The Chairman of each region is empowered to deal with matters which are preliminary or incidental to the hearing and may take steps to ensure that the case is given prompt consideration (r.r5, 13).

MHRTs are administered by clerks appointed regionally by the Secretary of State for Social Services and as such, come under the auspices of the Department of Health and Social Security. In the London office, there are six clerks and the Chief Clerk responsible for the administration of tribunals in the four Thames regions, East Anglia, Oxford, Wessex and South Western regions. The clerks receive the application from the patient; send out necessary notices; obtain the statement from the responsible authority; send copies of documents to the applicant; arrange the time and place of hearing; pay expenses; inform the applicant and other interested persons of the tribunal's decision. The Tribunal and Inquiries Act 1971 established the Council on Tribunals to review the working and construction of tribunals, including the MHRT. The Council has no power to enforce any action following complaint against an MHRT. It must be consulted however, when procedural rules are made or amended.

Applications and References

Patients detained under the Mental Health Act 1983 for up to 72 hours are not entitled to apply to a Mental Health Review Tribunal for discharge. Patients otherwise detained may apply during a period specified in the Act. In some cases, the nearest relative may apply or the patient may be referred at the discretion of either the Secretary of State for Social Services or the Home Secretary. Cases are automatically referred to the tribunal for the first time under the 1983 Act if, during a specified period, the patient has not appeared before the Tribunal. The Act places upon the responsible authority or upon the Home Secretary this duty to refer cases to the Tribunal.

Powers of MHRT's

The Tribunal 'is organised around legal concepts which consist in essence of shorthand organising focuses for psychiatric nosological categories together with prognostic concepts in the application of which the psychiatrist is deemed to be the expert'.[19] The term 'mental disorder' is a generic term with particular legal significance and is not a medical diagnostic term. It is defined in S.1 of the MHA to include mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind. Mental illness is undefined in the Act, but it must be of a nature or degree which warrants the detention of the patient in the interest of his health or safety or for the protection of others. The Tribunal is not concerned with whether the admission procedures were properly carried out - nor is it directly concerned with how the patient is being treated in hospital. Its task is to decide whether he should be detained there any longer. The Tribunal's criteria are not identical to those for admission[20] but the general effect is that it must discharge a patient if the grounds for detaining him do not exist. The burden of proof lies with the patient and the Tribunal need only be satisfied on the balance of probabilities 'although we all know how difficult it is to prove a negative'.[21] A person cannot be detained on the basis of mental disorder alone; in addition detention must also be necessary either for his own health or safety or for the protection of others. These - as Gostin et al[22] point out - are not purely psychiatric preserves. Issues such as whether or not the patient understands the need for treatment or would be able to care for himself if discharged or whether the necessary treatment could be given in a less restrictive setting - need to be examined.

Detention under Section 2

After considering an application, a Tribunal may direct that a detained patient is discharged. In certain circumstances the patient must be discharged - the function of the Tribunal being primarily to decide whether it continues to be appropriate to detain the patient, 'not whether the treatment is or is not required'.[23] When admitted for assessment under S.2 of the Mental Health Act, the Tribunal may direct a patient to be discharged on any grounds (S.72(1)). The Tribunal must discharge the patient if satisfied (S.72(1) (a)) that (a) the patient is not then suffering

from mental disorder or from mental disorder of a nature or degree which warrants detention in hospital for at least a limited period for assessment or for assessment followed by medical treatment or (b) the patient's detention is not justified in the interests of his own health or safety or with a view to the protection of other persons.

The use of the word 'then' in (a) is significant in that it makes clear the contention that the Tribunal does not require justification for the admission of the patient but that it is the continued detention which is under review. It is to be noted, however, that the Tribunal has a general discretion to discharge even if the above criteria are not satisfied.[24]

Detention under Section 3

When admitted for treatment under S.3 of the Act, the patient may also be discharged at the Tribunal's discretion which is not subject to any specific statutory criteria. The Tribunal has a mandatory duty to discharge if it is satisfied (S.72(1) (b)) that: (a) the patient is not then suffering from a mental illness, psychopathic disorder, mental impairment or severe mental impairment or from any of those forms of disorder which makes it appropriate for him to be detained in hospital for medical treatment; or that (b) it is not necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment; or (c) in the case of an application by the nearest relative following the barring of a discharge order, that the patient, if released, would not be likely to act in a manner dangerous to other persons or to himself.

In exercising its general discretion to discharge, the Tribunal must have regard (S.72(2)) to the likelihood of medical treatment alleviating or preventing a deterioration of the patient's condition; and (in the cases of patients suffering from mental illness or severe mental impairment) the likelihood that if discharged the patient will be able to care for himself, obtain the care he needs, or guard himself against serious exploitation.

The Tribunal may direct discharge on a future date, recommend leave of absence or transfer to another hospital, or guardianship.

Pre-hearing Procedures

Applications to the Tribunal must be made in writing by the applicant, a person authorised by him, or his representative and must contain certain information. An application may be withdrawn at any time, subject to the Tribunal's agreement and it is as if no application had been made. Once an application has been received, the Tribunal is appointed and the chairman is empowered to exercise preliminary and incidental powers, for example, to call for further information and reports (r15) or to deal with any irregularities that arise (r28).

Any party to the proceedings may be represented and Legal Aid in the form of Assistance by Way of Representation (ABWOR) is available to the applicant, although another party seeking representation would need to bear the cost. A representative may be any person except a patient liable to be detained under the Mental Health Act, or a person subject to guardianship under the Act or receiving treatment for a mental disorder in the same hospital as the applicant. The Tribunal may appoint someone to represent a patient if he does not wish to conduct his own case, but it is not under any duty to do so - nor is the applicant bound to accept any appointee.

Access to Medical Information

It is usual for the Tribunal to have before it a statement of the responsible authority, which includes an up-to-date medical report (which it has a duty to provide) and - 'Insofar as it is reasonably practicable to do so'[25] - a social circumstances report. It is permissable under rule 6 (4) for the responsible medical authority to set aside any part of its statement when it is considered that full disclosure to the applicant would adversely affect the health or welfare of the patient or others. Fennell[26] writes that the most frequently given reason for non-disclosure is that it would impair the doctor/patient relationship. This is based on the assumption that the relationship itself is based on co-operation - which, of course, it is not. If, the Tribunal decides that information should not be disclosed to the patient, it must disclose every document to the patient's representative provided that person is 'authorised' - i.e. a barrister or solicitor, a doctor

or another perosn whom the Tribunal considers to be suitable. When information is to be withheld from the patient, the representative must not disclose it directly or indirectly without the Tribunal's permission. If a patient is not allowed to see part of the medical authority's statement, the usual principle of natural justice - that a person is entitled to know the case against him - does not exist and, as Fennell has pointed out[27], the patient becomes a passive source of information, unable to participate fully in the proceedings. If, as Brenda Hoggett states, MHRT procecdure has always been designed on the assumption that full disclosure 'May be harmful to the very people whom the proceedings are trying to help ...'[28], it seems that legal representation before Mental Health Review Tribunals is very necessary. But it would appear that non-disclosure can also extend to independent psychiatrists and social workers instructed by the patient to provide a report for the Tribunal[29], which seriously impedes their ability to reach informed, balanced conclusions.

The medical member of the Tribunal must examine the patient before the hearing. The original purpose of this was to give the Tribunal its own objective medical opinion, so that independent reports were rarely needed. Brenda Hoggett raises two objections to this within British legal tradition - 'a doctor who is to play a part in deciding whether the patient is fit for release will obviously approach his examination in a different way from a doctor whose responsibility is to the patient himself. The other problem with the medical member's role is one of natural justice. He gives his opinion in confidence to the Tribunal with no formal opportunity to challenge it. In some areas, he gives the other members his views before the hearing - though difficulties also arise if his opinion is kept until the decision-making stage'.[30] Despite the fact that the medical member's opinion is considered as part of the Tribunal's deliberative process, Gostin et al[31] would argue that the evidence and information upon which the opinion is based should be disclosed to all parties.[32]

The Use of Medical Information

There are no guidelines as to what is required in the Responsible Medical Officer's report. It is obviously a highly influential in determining the Tribunal's decision. Fennell[35] points out that reports can be presented in such a way as to rationalise diagnostic and prognostic conclusions and may

contain substantial errors. While cross-examination of witnesses is permissible in MHRTs, it is important to remember that the Rules require that the Tribunal adopt an informal approach - the purpose being to encourage open discussion among the parties. It is important to stress, however, that even a lawyer representative will find it difficult to challenge effectively the diagnosis or prognosis of the psychiatrist.[36] If challenged, the Responsible Medical Officer will invoke the concept of insight which, according to Fennell, may be used to depict a recognition by the patient that he is suffering from a mental disorder and a recognition that the psychiatrist knows best. The main problem with this is that 'if insight is the recognition of one's madness it is not possible to recognise it and be sane'.[37] The concept of insight may be used in another way - it may be used to depict the recognition by a patient that previous pathological courses of action are to be understood as wrongful acts. This process involves two elements - firstly, the patient must be able, now, to theorise about the behaviour and secondly, the patient must be remorseful. In Fennell's wonderfully sceptical view of the balance and fairness of tribunals "the use of insight as a legal tool automatically ensures that the patient's rebuttal is a part of his symptomatology".

In deciding whether or not the patient is suffering from mental disorder and whether or not he should be detained, the Tribunal is performing both diagnostic and prognostic functions. This involves an appraisal of his present condition, evaluation of his life history and an assessment of the possibilities at least for the immediate future. It goes without saying that the Tribunal needs accurate information in order to reach an informed decision. In the interests of justice, the patient needs to be able to test the accuracy of the reporting of his alleged behaviour, to set it in context so that its relevance to the matter in hand is clear and beyond doubt. Fennell writing in 1977, saw the MHRT as merely a patient's welfare assessment panel. The increase of formalism may not be the solution to all of the Tribunal's obvious drawbacks, but it may mean that the legal criteria for detention are taken more seriously with focus on the issues and a more careful scrutiny of the facts.

Conduct of Proceedings

The Tribunal has a general duty to conduct the proceedings in the manner which it considers suitable. Informality is believed to encourage the parties to discuss the case openly with minimum confrontation, although there are statutory rules governing the right to give and to hear evidence, to call witnesses, the interviewing of the patient by the Tribunal, etc.

The Tribunal may adjourn at any time (r16(1)) and, in theory, will normally grant a request for adjournment by a representative if made on reasonable grounds (to consider evidence not previously available, for example). The Tribunal's decision is a majority one and is recorded in writing, although full disclosure to the patient may not be permitted. Under rule 13, there is a general power to give any directions to ensure the 'speed and just determination of the application'. Undue delay in determining an application may constitute a breach of article 5(4) of the European Convention on Human Rights.[38] Failure to comply with the rules does not necessarily render the proceedings void, (r28), but where the Tribunal considers that a person has been prejudiced it must take steps to cure the irregularity before reaching a decision. It may if necessary, amend a document.

Failure to correct an irregularity may constitute grounds for an appeal by case stated under S.78(8) of the Mental Health Act. This means that a representative can ask the Tribunal to state a case for determination by the High Court on a point of law decided by the Tribunal in the course of its proceedings or judgement. Appeal of a decision by way of judicial review has according to one source,[39] increased since the introduction of the Mental Health Act 1983. This procedure is available on any question of law and can therefore be used to challenge a breach of the duty to act judicially. The Tribunal has no powers to deal with contempt of its proceedings, but may, if necessary, refer matters to the High Court, where they will be treated as if in contempt of court.

Assessment Applications

There are specific rules for applications from patients detained for assessment under S.2 of the Act and which apply only to this category. Such patients may apply to the Tribunal within the first 14 days of admission (S.2 provides that a person may be liable to be detained for up to 28 days). The hearing must be no later than 7 days after receipt of the application - the date fixed by the Tribunal when it receives the application. An up-to-date medical report need not be submitted and the Tribunal may hear the case without it although the responsible medical authority should provide copies of the admission papers and such information specified in Sched 1 Part B of the Rules 'as can reasonably be provided in the time available (including a social circumstances report) and that information specified in Sched 1 Part A (including the patient's name and address, next-of-kin, previous hospital admissions, etc.) 'as is within the knowlege of the responsible authority'. In Mental Health Review Tribunal Procedure, Gostin et al suggest that there may be little information submitted to the Tribunal in respect of assessment applications[40], and more than usual use of oral evidence. Certainly, Tribunals have always have had inquisitorial powers and according to Brenda Hoggett[41] this has been the predominant model in the past which is a view shared by a regional MHRT chairman.

The constraints of time in the consideration of assessment applications mean that certain rules do not apply, but the Tribunal cannot suspend any rights under the Rules nor under the rules of natural justice for the sake of expedition.

Assistance by Way of Representation (ABWOR) is assistance given to a person by acting on his behalf in the proceedings before a court, tribunal or statutory enquiry. It may, under the Legal Advice and Assistance (Amendment) Regulations 1982, cover the cost of obtaining the report of an independent expert or instructing counsel. ABWOR was extended to MHRTs in December 1982, but it is to be noted that approval to instruct counsel is unlikely except where a difficult point of law is to be considered or where - for other reasons - counsel is better able to represent the applicant. The opinion of an independent expert cannot be obtained without prior permission of the Law Society. It is, however, generally given for a psychiatric report.

Is Justice Done?

When Tribunals were being discussed in the Committee stages of Mental Health Bill, 1959, the need for a representative to act and speak for the patient was debated. The then Minister of Health agreed that the patient should be represented by a lawyer or any other appropriate person if he so wishes[38]. Writing in 1970, Greenland noted that some 35% of those represented were discharged by the Tribunal - as opposed to 8% of those who were unrepresented. He described an 'ineffable constellation of circumstances which influenced the Tribunal to rule over the detaining authority' and outlined five key questions, the answer to which would indicate whether or not a tribunal could be regarded as having served its purpose - that is whether 'justice is being done, and is being seen to be done'.[39] For Greenland, the key questions were:

(1) was the applicant, patient or relative given a full opportunity to present himself and his case in the best possible way?

(2) did the Tribunal establish that statements made by the responsible authority were accurate?

(3) was the applicant given the opportunity to refute any allegations made about him?

(4) was the conduct of the Tribunal designed to protect, rather than undermine the future relations between doctor and patient?

(5) were the proceedings conducted with dignity, impartiality, and proper concern for the liberty of the individual?

Larry Gostin suggests that independence is the most important aspect of review. Independence demands the ability to assess information presented by both parties, with access to all relevant information and the ability to identify gaps in the evidence. It also demands an unbiased assessment of that information in accordance with relevant statutes. In her paper[42], Jill Peay's findings were alarming in this respect. She noted that for example,

(under the 1959 Act) the emphasis on therapeutic goals resulted in 'an unnecessary reliance on medical integrity and a general emphasis on the medical approach'.[43] This, she suggests, militates against any emphasis on legal procedures or control of medical discretion. Another factor affecting the independence of Tribunals is that the nature of their decisions is essentially predictive. The paucity of information available to Tribunals in making decisions resulted in for example, assessments of the patient's behaviour outside of hospital, which were necessarily speculative. The net result being 'that the information deficiencies, combined with the tendency to emphasise therapeutic rather than legal considerations, may unduly bias Tribunals against the likelihood of reaching discharge decisions'.

Coupled with this, Peay found that the individual members of the Tribunal bring with them certain assumptions about their role, both as individuals and as members of a group - for example, that psychatric, legal and lay considerations contribute equally to the final decision. Such assumptions - according to Peay - are unsupportable and are compounded by the lack of feedback members receive about the outcome of their decisions and the lack of training for members. To date, Tribunal members are given no training although the matter is receiving consideration. Another factor, of which the Lord Chancellor's department is aware, is that Tribunal membership is drawn from a social grouping which is substantially different from the vast majority of applicants. Jill Peay found that 'members did not appear to conceptualise their role as that of a judicial body, but rather as an informal reviewing panel, intended to assess the most appropriate course of action, taking into consideration their conception of the patient's 'best interests', and were prepared to disregard or circumvent the Tribunal rules to do so. Further, she found that only 29% of those members taking part in her study (200 in total) were aware of their permissive power to discharge as opposed to the circumstances under which they have a <u>duty</u> to discharge. Thus taking into account the frequency with which members sat on Tribunals, she calculated that patients have a one-in-three chance of appearing before a Tribunal where the members are unaware of their powers. She concluded that the efficacy and justice of Tribunal decisions had to be questioned since her research - conducted between 1976 and 1980 - ' indicated that both the nature of the law, its present method of group application and the nature of the task members are required to fulfill, facilitate the expression of individually based decision preferences' which she demonstrated to be based on the mistaken

opinions of the members. This is attributable to the Tribunal system itself which 'is felt to be at fault because it provides neither unambiguous decision criteria, nor an appeal system for clarification of those decision criteria, nor even effective feedback about the outcome of the decisions taken'.[44] The 1983 Act did attempt to counter such criticisms, but as Jill Peay forewarned in 1981, the legal criteria or procedural basis for Tribunal decisions have remained ambiguous, primarily because the decision-making process itself remains unchanged. Jill Peay recommends that - for any real improvement in the Tribunal system - members would benefit from training which would make clear some of the factors and pressures bearing on the decision-making process, and could provide guidance for clarifying issues or criteria which remain ambiguous. A further recommendation is that the Tribunal would obviously benefit from a written report presenting the case for discharge, prior to the hearing. This, she suggests, may be prepared by the patient's representative and would certainly counter the built-in bias which pervades the whole Tribunal system[45], because the decision-making body, the MHRT, has no power to make its own investigations and is therefore entirely dependent upon evidence placed before it.

Representation for patients

The work of Jill Peay indicates that representation before the Mental Health Review Tribunal is necessary to redress the balance. She found that non-medical members of the Tribunal had more faith in their medical colleagues than the latter had in themselves. Fennell[46] states that 'the representative is more valuable as a social worker and fixer, than as an advocate'. David Mawson's[47] findings at Park Lane Hospital would indicate that this (social work) element of the representative's role is extremely important in the decision to discharge. Gostin[48] says that the intention behind the Mental Health Review is to provide a full and fair hearing without secrecy. 'This requires basic procedural fairness including the right to appear with publicly-funded representation and independent expert advice'.

The right to representation is certainly well established in the legislation and is inherent within the principle of natural justice. However, in the mental health context the patient may be disadvantaged through isolation, confusion, lack of knowledge as well as detention in hospital - all of which make the preparation of a case difficult, if not impossible. The right to representation may be well established and is certainly increasing[49] but there is no doubt that representatives and their clients face difficulty and sometimes hostility from a system which operates entirely in the interests of the patient or of society.[50]

For example, the Tribunal has almost unlimited discretion as to the conduct of the hearing. The Responsible Medical Officer can request the exclusion of the patient and can request that part of his (highly influential) report be withheld from the patient - none of this would be contemplated in the criminal courts.[51] The fact that Tribunal decisions are unreported militates against consistency. Carol Stephens describing the MHRT as a hybrid institution[52], notes that the medical member is a fact-finder, which is an element of the inquisitorial model. This phenomenon means that his findings are part of Tribunal's deliberations and are therefore secret. Further, in Mental Health Review Tribunals, hearsay evidence is permissible.

Despite this very obvious bias against the patient, there is still a large body of opinion which is opposed to the view that the representative should act on the patient's instructions alone. This body includes some lawyers and psychiatrists alike and is completely in line with 'the best interests' view and the view that psychiatry is a special case. The role of the legal representative though, is not to challenge or oppose psychiatry per se, but to test the strength of psychiatric evidence and words such as 'risk' 'health and safety', 'danger' etc. In a debate on formalism in Mental Health Review Tribunals, Prof. Sir John Wood (Chairman, North West Region MHRT) argued against formalism principally on the ground that the statutory criteria are 'vague' and 'not conducive to clarity'. Whilst agreeing that much of current practice is unjust he described 'detainability as a concept riddled with dishonesty', Sir John opted for a middle road between formalism and informality 'to maximise the chances of the patient to maintain his level of functioning'.

Nevertheless, representation before the Mental Health Review Tribunal is a right and doubly important because the applicants have lost their liberty and their personal autonomy. The representative's role can be summarised as follows:

- taking the client's instructions
- gathering information about social circumstances or facilities if discharged
- obtaining independent reports
- verifying facts in medical and social work reports
- formally testing evidence
- ascertaining the effect of medical treatment
- arranging for witnesses to appear for patient
- focussing Tribunal members' minds on legal criteria whereby the patient must be or may be discharged.

MENTAL HEALTH REVIEW TRIBUNALS AT SPRINGFIELD HOSPITAL IN 1985

The aims of the Advice and Legal Representation Project as set out in the original funding application to the King Edward's Hospital Fund for London included a commitment to evaluation. The independent evaluation of the Project undertaken by S.C.P.R. confirms that the types of problems presented to the project are largely as envisaged at the time of the original application - with one exception, Mental Health Review Tribunals. Negotiations with the Hospital prior to the setting up of the Project and a consideration of the experience of Middlewood Hospital C.A.B. indicated that Tribunal representation could not be expected to exceed two or three cases per year. Mental Health Review Tribunals at Springfield Hospital, prior to the Project being set up were (according to the Patients' Affairs Officer at the time) 'a rarity'. In 1980 there was one applicant to the Mental Health Review Tribunal from Springfield Hospital. He was a S.26 (MHA 1959) patient, he was unrepresented and was not discharged. In 1981, there were four MHRT hearings. None of the applicants was discharged - three having been detained under S.26 and one under S.65 (MHA 1959). In 1982 the Project represented patients on three occasions; in 1983, the figure was six; in 1984, four.

It is not clear, nor is it the purpose of this paper to ascertain the reason for any increase in the number of MHRT applications or hearings, but the passing of the Mental Health Act 1983 undoubtedly increased the opportunities for applications to be made, by extending the rights to apply to patients detained for assessment under S.2. There were 24 applications to the MHRT between 1 February 1985 and 31 January 1986 from patients in Springfield Hospital.

Unofficially, a clerk at the Regional Office of the MHRT could see no significant difference in the number of applications to the Tribunal between Springfield and other hospitals. The difference lies in the number of applicants who are represented. He estimated that generally 40 - 50% of applicants are represented. In 1985 at Springfield Hospital, the figure was 87.5%.

The fact that so many Tribunal applicants have been represented by Project staff has caused some conflict between Project and Hospital medical staff - some suggesting that representation by an outside solicitor would be preferable. The independent evaluation of SCPR found that the 'complexity and sensitivity of the Tribunal situation is complicated by three issues that stem from the Project staff sharing the same institution and setting, but where the same rules do not apply. The first ... is the apparent questioning of professionalism that is implicit in the challenge at a Tribunal of a doctor's medical opinion ... The second issue surrounds the Project's independence from the hospital ...'. The third issue is that the Project's method of working cannot be incorporated within the 'concensus model' operating in parts of the rest of the hospital....'[55] It has been a contentious issue - correspondence was exchanged with the Hospital Medical Committee in 1984 and the Project's Management Committee undertook to review the practice of providing Tribunal representation. The commitment to providing representation was reaffirmed but with little idea of the nature of the problem as perceived by medical staff and the need for the service as perceived by the Project's clients who apply to the MHRT. With this in mind, it was decided to appraise the work of the Advice and Legal Representation Project at Springfield Hospital with reference to representation at Mental Health Review Tribunals. The difficulties with this proposal were, firstly, the 1983 Act came into force in 1984 and had a great effect on attitudes to the Tribunal, to the issue of rights in general and representation in particular. Secondly, the nature

of the subject matter is such that polarisation of opinions can be extreme. Patients can be asked for their recollections of an event which took place at least a year previously which for some can be very painful. Thirdly, the overall number of hearings at Springfield was small - 24 in the period selected - rendering any findings impressionistic and subjective. The subjectivity of any attempt to study the operation of the Mental Health Review Tribunal is well enough documented - but the fact that the impressions of the participants in this paper reinforce many of the findings of Peay et al, indicates that the change in legislation has had little effect for the patient.

The Study

This study covers the period 1st February 1985 to 31st January 1986, which is the first complete year, after the introduction of the Mental Health Act 1983, for which the Project's statistics are available. Interviews were carried out with six members of the medical staff at Springfield who have appeared before the Tribunal. Two members of staff at the Advice and Legal Representation Project were interviewed as well as six patient clients who were represented at the Tribunal either by Project staff or where counsel was instructed. One patient who was not represented and two representatives from firms of solicitors outside the hospital also agreed to take part. The views of the writer must obviously play a part since she was the representative (or briefed counsel) for six of the hearings in question. Those taking part were asked to consider (at least) the following points, based on Greenland's key elements, although interviews were not formally structured:

(1) The function of the MHRT

(2) The success of the MHRT in fulfilling its function

(3) The most important factor influencing the Tribunal's decision

(4) The need for representation

(5) The role of the representative

(6) Fairness in terms of their ability to put their (or their client's) case to the Tribunal

The Hearing

'Hospitals vary in their attitudes towards tribunals. Some enthusiastic doctors see an application as a helpful step in encouraging the patient to take responsibility for himself, some as a way of sharing or relieving their own responsibility. Some may see the tribunal as a threat to their professional judgement, although it has no jurisdiction over questions of treatment ...'.[56]

Of the 24 Tribunal hearings at Springfield Hospital between 1st February 1985 and 31st January 1986 only seven patients did not approach the Advice and Legal Representation Project for advice and/or representation. Unusually, one of the seven was approached by Project staff at the request of nursing staff. This patient refused any kind of help however and preferred to present her own case to the Tribunal, although she did accept pen and paper in order to make her application. The seven who were unrepresented were not discharged by the Tribunal. In one case, where the patient was unrepresented the hearing was adjourned (to take place five days later) because of non-attendance of the patient's mother. In another case, where the patient was referred to his own solicitor, the hearing was adjourned once because his representative did not attend. The rearranged hearing (almost one month later) was adjourned again because the Tribunal failed to provide a lay member. The third and final hearing was three weeks later - the patient was not discharged.

Four patients approached the Project but were eventually referred to outside solicitors (including the patient just mentioned).

Of the eleven patients who were represented by the Project, two were detained under S.3 of the Mental Health Act 1983, one was detained under S.37 with restrictions under S.41. The remaining eight were admitted for assessment under S.2. Two of the total eleven had appeared before the Tribunal on a previous occasion. Counsel was instructed on four occasions, once because of the 'sensitive nature'[57] of the case, and with the restricted patient because of the complexity of his case. On another occasion, counsel was instructed because it was felt that S.2 was being used unlawfully and there was the need to put this argument effectively. This was upheld by the Tribunal.

Six of the patients represented by the Project were discharged by the Tribunal. This represents 54.5% as opposed to the generally accepted 17% (Peay, Mawson et al) and the 10-20% estimated by the S.W. Regional Office of the Mental Health Review Tribunal.

The Client

All the patients and representatives who gave their views for the purposes of this paper expressed concern at the difficult and painful experience which constitutes a Tribunal hearing for the patient. Words like 'gruelling' were used by almost everyone. Perhaps the Tribunal's task cannot be fulfilled without uncovering painful facts and events, but the total disintegration of a person's shaky self-confidence is difficult to witness - particularly when it is supposed to be in that person's best interests. One woman stoically sat through a debate, which was rather one-sided, about the exact meaning of 'liable to be detained' and which was entirely over her head. This appeared to be for the benefit of the many observers permitted to attend the hearing by the Chairman, who was a judge who later dealt with the patient's concerns about (drug-induced) weight gain in a most unsympathetic way. This woman, who was on leave from hospital on the day of the hearing, travelled some way to attend at her own expense, waited while two other cases were heard before hers and left at the end of the day, demoralised and feeling 'really silly'. She had an independent psychiatric report which was in favour of discharge from hospital and which had corrected a number of discrepancies in the Responsible Medical Officer's report. The main justification for her continuing liability to detention was that she may, at some point in the future, relapse.

This feeling of inadequacy was echoed by another patient, who felt that Tribunal members did not understand him, that they were a lot more well-spoken than he was and, at the end of the day, 'got on better with the doctor' (RMO). The reports in this case - as is usual with assessment applications - were made available to the patient and his representative immediately before the hearing, so it was impossible to verify facts or seek out witnesses. In fact, this patient's representative was horrified at

the seriousness of the allegations which were made against her client but which remained unsubstantiated. These, she felt, had a bearing on the Tribunal's decision not to discharge her client since they involved attacks on young children and were recorded in such a way as to sensationalise them. But the decision was justified as per the legal criteria for continued detention.

Another patient was angered by the fact that reports were not made available until immediately before the hearing and felt that this seriously hampered his ability to present his case effectively, as he was unable to counter allegations made in the reports. He went on to say that although he was pleased that he had representation he felt that the proceedings did not allow effective presentation of his case and that the matter was conducted for the benefit of the RMO, a feeling echoed by all other patients interviewed. This patient has appeared before the Tribunal on two occasions. He was ill - he says - on both admissions but feels the Tribunal unfair because 'it is up to the doctors to make a devastating case for keeping me here'. To appreciate this man's bitterness it is necessary to know some background to his case. He had previously been admitted to hospital on many occasions, almost always seeking informal admission in the first instance when he realised he had reached crisis point. He has never been - nor has it ever been alleged that he has been - a danger to himself or others and yet he feels that on at least two occasions he was detained in hospital on the basis of half-truths and out-of-context reporting which he has lacked the ability to challenge. He firmly believes that representation before the Tribunal is essential as 'legal points need to be monitored'.

Another patient who has appeared before the Tribunal more than once, felt that the proceedings gave an appearance of fairness whilst relying heavily on the RMO's report. This patient had the benefit of a favourable independent psychiatric report but was not discharged. Hers was the only case where non-disclosure was requested for a part of the medical report. This, she said, made her realise that her application would not be successful. She also pointed out that since her hearing was 5½ months after her admission under S.3 (which provides for admission for up to six months), no other outcome could be considered or expected.

This same highly articulate patient was scathing about the choice of members to hear her application. She was adamant that the Tribunal - and in particular the lay member - was unable to understand her problems. The lay member, she felt, must have lead a very sheltered life to question her on such an excrutiatingly banal level! (This view is supported by the writer). This woman was justifiably bitter about her treatment by the Mental Health Review Tribunal, although fully appreciative of the administrative difficulties faced by that body and its procedural constraints. The decision not to discharge was based on the RMO's report, which had been withheld from her, so she was, in effect, unaware of the nature of the case against her - and still is. The experience was, 'an ordeal' and she would not have wanted to attend unrepresented not knowing what to expect. Subsequently she feels that representation is necessary - because she does now know what to expect.

Another patient, whose continued detention for assessment was justified in the interests of her own health was very bitter at the outcome. The Tribunal had the benefit of an extensive medical report outlining the case against discharge and the private evidence of the patient's parents. This woman did not have a social circumstances report because the Social Services Department was working to rule. All the Tribunal heard was the case against discharge and, as she put it, 'nothing good about me' apart from her own evidence. In fact, according to her doctor this woman was, responding well to medication, but he was concerned about her 'very real marital difficulties' and the fact that, should she be discharged, the marriage may break up!

Those patients who were discharged by the Tribunal obviously felt much more positive about the whole process and about their ability to put across their point of view. However, they were, in fact, discharged for a variety of reasons, the ubiquitous 'insight' notable in its absence. On one occasion the RMO came back from leave to find the patient no longer suffering from mental illness and therefore agreed with the representative that the patient should be discharged. On another occasion, the same RMO was forced to agree with the Tribunal chairman the fact that the patient suffering from mental illness was not, in itself, sufficient to deprive him of his liberty. One elderly woman, whose whole demeanour and appearance aroused the sympathy of the Tribunal, was discharged as soon as appropriate arrangements could be made for support in her (very large) house. Her RMO when required to give his reasons why informal admission was not possible, had merely stated 'because she refuses'.

Another patient was discharged - although suffering from mental illness in the Tribunal's view - because his girl-friend felt able to take responsibility for ensuring that he would take medication and attend the outpatient clinic.

From the patient's point-of-view, the best that can be said about the Tribunal is that it sets out to be fair, but in the words of one of the clients of the ALRP, 'it is not the best way of eliciting the patient's point-of-view'. Interviewees tended towards the view that justice is not being seen to be done. Perhaps this could be remedied to some extent by the adoption of Brenda Hoggett's suggestion that (in assessment applications) 'the burden of proof ought to be placed on the authorities to justify their actions. If they cannot do so there should be some way of 'wiping the slate clean' for the patient'.[58]

The Responsible Medical Officer

'It is in the operation of the Mental Health Review Tribunal that the consequences of the medicalisation of madness law are most glaringly made manifest, and the more coercive aspects of the doctor/patient relationship are clarified'.[59] Certainly, the 1959 Act operated under the assumptions that mental illness is capable of diagnosis and treatment and that doctors are competent to recognise this and need to have the power to administer treatment in the patient's interests. The 1983 Act represented some attempt to exercise a degree of control over the activities of psychiatrists, and to satisfy the call for the right to treatment and the right to refuse treatment. Old habits however, die hard. Increased access to the Mental Health Review Tribunals, particularly before the 1983 Act came into force was greeted with cries of horror from the medical profession which, feeling acutely the diminuition of its power, was probably resentful of the implication that the profession has failed. The prevailing view in the mental health field cannot now be described as 'therapeutic optimism' and it must be said that pharmacology has been seen to have its limits.

Two of the consultants interviewed have obviously found it difficult to come to terms with this movement away from total confidence in psychiatry. One was speechless at the suggestion that not everyone is prepared to see psychiatry as the main element in the care of the mentally ill because 'social workers cannot administer phenothiazines'. He also felt it was difficult to imagine that doctors could act otherwise than in their patients' interests. Another medical officer found it hurtful that 'lawyers have the idea that doctors are against their patients'. Both these doctors found MHRTs cumbersome and felt that they got in the way of patient care, one of them thought there was 'too much paperwork with this Act'. His colleague felt that representation before the Tribunal was certainly a waste of time if the representative was not a medically-trained person.

It has to be said that psychiatrists whose orientation is so narrowly focussed on the medical model appear to be in the minority at Springfield Hospital. Others spoke of the need for a review of detention as a necessary safeguard, although one expressed some irritation with the vagueness of the legislation and concepts such as 'mental disorder'. He expressed the view that this lack of clarity certainly contributed to feelings of unease about the possibility of challenge before the MHRT.

None of those interviewed admitted to any of their opinions being changed as a result of discussion at the hearing, or as a result of the independent medical report. One spoke of creative tension which, he felt, could be worked with. Another saw the Tribunal as being helpful in providing a a wider perspective on the case of his patient who was of a different culture and whose relative was able to explain matters of cultural significance to the Tribunal and to the RMO.

Two doctors felt that psychiatric evidence did not fit into an adversarial approach, it was difficult to be exact about prognosis, the degree of risk one was prepared to take etc. One doctor thought it all very well for the Tribunal to discharge patients because that body takes no responsibility for such decisions, whereas doctors do, and there were often recriminations following a 'bad' decision.

Apart from the two already mentioned, the doctors felt that on the whole the Tribunal was fair, well-considered and useful, but as one pointed out expressedly, none felt the outcome had been contrary to their opinions. Most were concerned about the lack of time to prepare reports in assessment applications, although two felt strongly that if a patient had been sectioned, then the RMO ought to be able to justify his/her action. All expressed some irritation that they had to rearrange timetables at short notice, particularly if they considered it to be a trivial application. None was aware that the medical report is not crucial to the proceedings and only one that the RMO may appoint a junior doctor to attend the hearing in his place. (The Regional Chairman, when asked about the lack of time in assessment applications said he was surprised as there had been no complaints from RMOs or hospitals, reports were always ready and RMOs almost always attended hearings in person).

Some doctors spoke freely about the need to challenge medical opinion and and the need for doctors to have to justify their actions. Four doctors in particular spoke about the need for representation as a patient's detention in hospital may render him incapable of preparing a case. Here - and only here - was the merest hint of the original problem. While one doctor was happy, indeed felt it necessary that representation is available 'in house' (he felt he 'needs to know that the representative cares about the patients'), another believed that on an emotional level 'in house' representation is still difficult to accept, and that with outside representation there is no blurring of roles or boundaries.

The Representatives

As was expected, representatives as a group were most clear about their role, the function of the Tribunal and the need for representation.

Representation, they feel, is very necessary because of the isolation experienced by patients in hospital. It cannot be left to the Tribunal to get the evidence out, as clients are doubly impeded by being in hospital, possibly inarticulate and probably totally lacking in confidence. One person said that representation was necessary 'to give clients integrity, esteem and to maintain contact with the world outside'.

Not surprisingly, the court-like aspect of the Tribunal was emphasised by representatives. It's function is to decide on the interpretation of the law, and by applying law to decide the patient's fate. One said the function of the Tribunal is to test the evidence presented and to review the case. The court-like function was preferred because it was felt essential that the patient was heard and this ensured that was so. It was appreciated by one solicitor, however, that the nature of the proceedings and the subject matter made it difficult to hold on to the adversarial model, especially as some chairmen are idiosyncratic in their conduct of the proceedings allowing interruptions, and so on. The view that psychiatric evidence was not conducive to formal testing, was universally regarded as nonsense although one representative felt that an independent medical report made this aspect of representation easier - often providing an alternative view of treatment.

The representative's role, advising on the law and putting the patient's case to the Tribunal, was seen as necessary to ensure the Tribunal adequately performs its function. Informality was seen by most as good and bad. On one occasion it rendered the hearing to something akin to a shambles where the representative did not feel that she had been able to put the case for the patient. Informality may mean that the Tribunal can form some kind of rapport with the patient or can be less intimidating, but it can also be difficult for legal representatives to give up the control they usually have in more formal proceedings. In particular representatives commented on the fact that the chairman decides the order of the hearing at the outset. It is usual for the RMO to be questioned first by the Tribunal's medical member and some representatives felt they had little or nothing to add when this was the case. It was felt that there must be some degree of formality to ensure that all the evidence is brought out.

Hearsay evidence was regarded as a problem by all, and everyone felt it important to guard against misplaced emphasis on events, which sometimes coloured the case against their clients. One woman had 'answered the door brandishing a knife' - in fact she had been buttering the bread for tea and had answered the door with the knife still in her hand. All commented on the need to test psychiatric evidence. It was more difficult

to say, though what was the most important factor influencing the Tribunal's decision. One of the solicitors certainly felt it was the patient's previous behaviour and ability to form a relationship with the Tribunal which lead to the decision to discharge. One Project worker told of the case of an elderly woman who dressed in her fur coat for the hearing, whose background was obviously similar to the Tribunal members and who aroused their sympathy immediately. Patients themselves said they felt unable to communicate effectively with Tribunal members, even those patients who may be regarded as articulate, often citing class difference as the major stumbling block. One representative mentioned that the Tribunal seemed 'to want to know' about her middle class client and were anxious to form a complete picture of his situation before making a decision. Of the patients interviewed the one person who thought the Tribunal fair was a professional person whose education and background was very much upper-middle class. Project workers see other factors as also influencing the Tribunal in particular evidence of a support system outside the hospital. This corresponds with David Mawson's findings in relation to the effect of social enquiry reports and the provison of housing and income.

The Tribunal system was seen as attempting to be fair but not always succeeding. Militating against fairness were hearsay evidence accepted by the Tribunal and the unavailability of reports (in assessment applications) which meant that important facts could not be verified before the hearing. The fact that there was often a degree of waiting around in corridors for the hearing to begin, with patients becoming extremely anxious, was also cited.

Project workers did not find it all problematic to adopt the 'strict instructions' approach whereas one of the outside solicitors felt that sometimes she had to 'fudge the issue' and found it a difficult dilemna whether or not to advise her client as to the apparent hopelessness of a case. Others, however, saw it as the Tribunal's duty to decide on the outcome from the evidence placed before it, and one emphasised the need to take a full statement from the patient at the outset to minimise the risk of influence via medical and social work opinion. The representatives as a group felt it important that scrutiny was given to the reasons for detention and treatment and that it is necessary that the patient saw this process taking place. It was felt by at least one representative that the

adversarial model was necessary to avoid any semblance of collusion in the proceedings or to avoid any degeneration into something 'vaguely moralistic' in tone, somewhat akin to Fennell's 'welfare assessment panel'.[59]

Conclusions

An examination of the background of the MHRT shows, in Carol Stephen's words, a 'hybrid institution'[60] an inquisitorial body with adversarial elements. Writing in 1981, Jill Peay[61] found that Tribunals are neither just or efficacious for the patient. Subsequent change in legislation has increased the opportunities for applying to the Tribunal. The Act though, did not, and did not intend to, change the philosophical justification for the Mental Health Review Tribunal to make recommendations or discharge most of its applicants. For medical staff at Springfield Hospital, a minority see the Tribunal as a nuisance and consider such a legal safeguard as anti-therapeutic[62], saying that psychiatric evidence is not conducive to cross examination.

Those medical staff who saw review of a detained patient's case as necessary, felt representation to be a essential and, what is more important, saw the Tribunal as just, fair and entirely independent. None of this latter group would own to any feeling of their professional judgement being challenged, nor did they feel they were 'on trial'.

One of the psychiatrists suggested that there was a particular difficulty in accepting or tolerating an apparent 'challenge' from within the hospital, that is, from Project workers who appear as patients' representatives before the Tribunal. On the other hand he felt that any 'challenge' would be more tolerable from an 'outsider'. This is impossible to measure, but one could speculate that such a confrontation could be more uncomfortable for psychiatrists as institutional pressures must also exist (to a lesser extent, perhaps) for Project workers.

All of the psychiatrists interviewed insisted that they had 'not much to do with the Tribunal' and in fact hearings do not occur (in Springfield Hospital) with any great frequency. In the period studied, 31 applications

were made and 24 cases were eventually reviewed by the Tribunal, three patients having been discharged by the RMO before the hearing. Unfamiliarity with the legal criteria and with the Rules and requirements of the Tribunal certainly add to their 'nuisance' value from the medical staff's point of view. For example, all were unaware that there is no requirement for the RMO to attend the hearing or that an up-to-date medical report is not an absolute requirement. In other words, psychiatrists were unaware of the extent to which the Tribunal can accommodate them.

This is all too obvious for representatives, who felt that RMOs had a fairly easy time before the Tribunal, citing the ambiquity of legal criteria, for example, as militating in their favour. The psychiatrists on the other hand, saw this ambiguity as contributing towards their defensiveness concering MHRTs. For representatives, easily accessible representation is absolutely essential before the Tribunal, not only because the patient is taking part in legal proceedings, wherein the burden of proof lies with the patient, but also because of the added impediments of isolation, detention in hospital and lack of confidence. Added to this, representatives also expressed concern over administrative problems with the MHRT which can result in delay before hearing dates are set. The Tribunal's staffing difficulties are fully appreciated but these need to be seen in the context of the patient's anxiety and the fact that hearings occur when issues are no longer 'live'.

Similarly, the facilities for taking last minute instructions at Springfield Hospital are non-existent. This is, of course, particularly acute in assessment applications where reports are received by the patient immediately before the hearing. All of the representatives interviewed had experience of attempting to take instructions in a corridor, outside the room designated for the hearing, and often within earshot of the RMO and social worker.

For patients (all except one) the Tribunal was recalled as an unpleasant and unfair experience. They felt, without exception, that their problems were not understood nor were they listened to. The RMO however, seemed to form an immediate rapport with the Tribunal, and seemed to communicate on a mutually satisfactory level. One patient - who was in fact discharged by the Tribunal - recalled a 'struggle to be heard' and felt that his discharge was due to the fact that he had representation otherwise his evidence would have been entirely submerged.

Another patient's mental state at the time of his application meant that his (outside) solicitor at one time refused to act as his representative because he felt that the patient ought to be in hospital. This patient believed that being unrepresented put him at a total disadvantage and was, incidentally, extremely grateful that he was able to see a solicitor from the Project over a period of time as he gradually became more able to concentrate on his case. This would not have been feasible with an outside solicitor.

All of the patients were concerned about the amount of evidence that could be amassed against them. In assessment applications, there is scarcely time to arrange for an independent psychiatric or social work report. Often the case the patient will need to answer is not known until immediately before the hearing, to refute it seems an impossible task.

The Mental Health Review Tribunal is intended to provide an independent review of the justification for the detention of patients under the Mental Health Act (1983), to provide a full and fair hearing. This requires the right to representation, to receive independent advice and to have knowledge of all the information available[63] and to be able to answer the case against discharge, by calling witnesses if necessary. The review needs to bee conducted in such a way so that 'justice is seen to be done'.[64] Patients interviewed in this study do not have this experience of the Mental Health Review Tribunal. Without wishing to criticise individuals or individual Tribunals, improvements could be made so that the process appears fair to those who have in fact, already lost their liberty and autonomy. Supporting the findings of other writers (Peay, Hoggett, Fennell et al) it can be concluded from this examination of MHRTs at Springfield Hospital during one year, that the appearance of fairness would be greatly enhanced if the burden of proof were removed from the patient and lay instead with the responsible authority. Additionally, this study would support the establishment of training for Tribunal members, with attention and effort given to areas of recruitment, particularly of lay members. Current emphasis on community psychiatry suggests that mental health is seen in the widest possible context - Tribunal members need to know about local housing and after-care, benefits, employment prospects before they can reach informed decisions.

Finally it would be helpful to the formulation of the patient's case if the medical member's view could be made known, particularly in assessment applications, since it is unlikely that independent medical opinion will be available. In none of the cases considered in the study did the medical member appear to invite the RMO to consider an alternative mode of treatment. This may well have been considered by the Tribunal but the patient needs to know. They also need to know if there is an effective challenge to detain them and on what grounds the decisions have been made.

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Notes

1. The Advice and Legal Representation Project at Springfield Hospital 1982-1985: An evaluation. King's Fund Project Paper No. 59 (1986))

2. ibid.

3. Psychiatry, Human Rights and the Law. Roth and Bluglass (eds). C Cambridge University Press (1985). Administrative Problems facing MHRTs - a paper by Prof Sir John Wood.

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5. ibid

6. The Function of Mental Health Review Tribunal under the 1983 Mental Health Act. David S Mawson. Unpublished dissertation, October 1984. Birmingham University.

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9. Mental Health Act 1959: some issues concerning rule enforcement. Philip Bean. British Journal Law and Society 2, 1975.

10. ibid.

11. ibid.

12. The Mental Health Review Tribunal: A Question of Imbalance. PWH Fennell. British Journal Law and Society 1977, 4, 186-219

13. Bean - as 9 above

14. Fennell - as 12 above

15. Mawson - as 6 above.

16. Mental Health Law. Brenda Hoggett. 2nd ed Sweet & Maxwell 1984.

17. ibid.

18. Mental Health Review Tribunal Rules 1983 (SI 1983 No 942).

19. Fennell - as 12 above.

20. Hoggett - as 16 above.

21. ibiid.

22. Gostin, Rassaby & Buchan

23. A Guide to the Mental Health Act 1983. Robert Bluglass. Churchill & Livingstone.

24. Mental Health: Tribunal Procedure. Larry Gostin, Elaine Rassaby, Andrew Buchan. 1st ed Oyez Longman 1984.

25. MHRT Rules - as 18 above.

26. Fennell - as 12 above.

27. ibid.

28. Hoggett - as 16 above

29. Gostin, Rassaby & Buchan - as 22 above.

30. Hoggett - as 16 above

31. Gostin, Rassaby & Buchan - as 22 above

32. ibid

(33 and 34 deleted from text)

35. Fennell - as 12 above.

36. ibid.

37. ibid.

38. Barclay-Maguire - v - United Kingdom. Application 9117/80, 9 Dec 1981.

39 Paper given at a study day on MHRTs, 23 June 1986, by Oliver Thorold at King's Fund Centre. Organised by MIND and NW Law Conferences.

40. Gostin, Rassaby & Buchan - as 22 above

41. Hoggett - as 16 above.

42. Mental Health Review Tribunal - Just or Efficacious Safeguards? Jill Peay. Law and Human Behavior 5, 2/3, 1981.

43 ibiid.

44. ibid.

45. Part of Jill Peay's research was simulation exercise involving a hypothetical case and video recording.

46. Fennell- as 12 above.

47. Mawson - as 6 above.

48. Roth & Bluglass (eds) - as 3 above. Human Rights in Mental Health - a paper by Larry Gostin.

49. It was estimated that 40-50% applicants are represented in the SW Region. In restricted cases, it is estimated that 75% are represented.

50. Bean - as 9 above.

51. The Role the Representative before the Mental Health Review Tribunal. Carol Stephens. Unpublished dissertation, 1985, Brunel University.

52. ibid.

53. Legal Action Group debate - Formalism in Mental Health Review Tribunals. 30. June 1986. Prof Sir John Wood and Edward Fitzgerald.

54. KFC Project Paper No. 59 - as 1 above. Includes an evaluation of the work of the Advice and Legal Representation Project at Springfield Hospital, carried out independently by Social and Community Planning Research.

55. ibid.

56. Hoggett - as 16 above.

57. KFC Project Paper No. 59 - as 1 above.

58. Hoggett - as 16 above.

59. Fennell - as 12 above.

60. Stephens - as 57 above.

61. Peay - as 42 above.

62. Gostin - as 48 above.

63. Gostin - as 48 above.

64. Greenland - as 38 above.

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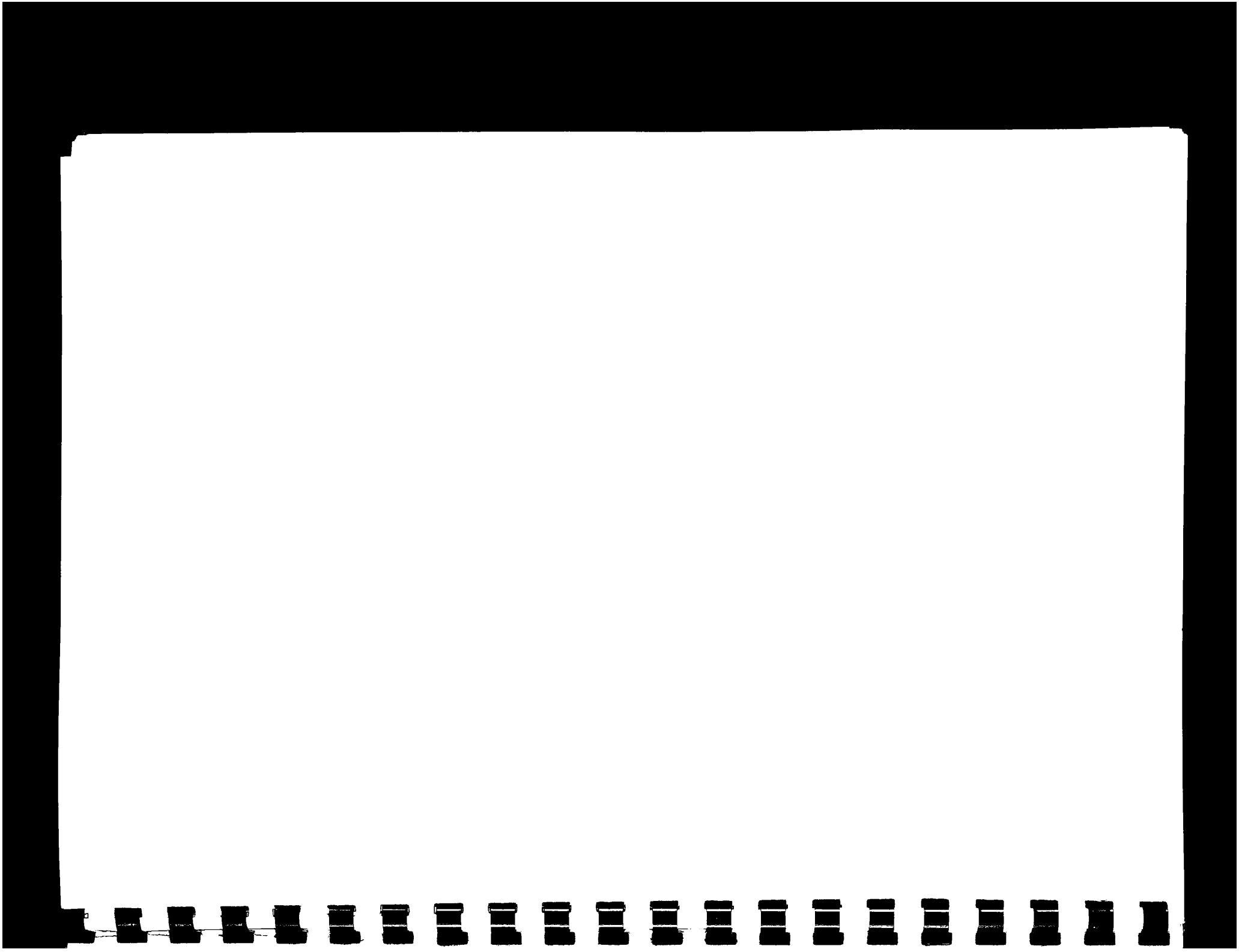

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