New recommendations aim to modernise and improve the appeals process for detained patients

Improving access to Mental Health Review Tribunals

KEY WORDS

Mental Health Review Tribunal

Mental Health Act 1983

Mental Health Act Assessment 2007

Treatment

Detention

The Mental Health Review Tribunal (MHRT) is an important safeguard for patients detained under the Mental Health Act 1983. All patients detained for assessment or treatment under the Mental Health Act can appeal to the MHRT against their continuing detention and treatment. The Mental Health Act 2007 amendments that are to come into force by the end of this year could lead to a slight increase in MHRT appeal hearings. The amended Act creates a single MHRT for England and a separate one for Wales. It also reduces the time span for some automatic referrals. Furthermore, with the introduction of supervised community treatment (SCT), patients subject to this will have more opportunities to appeal to the MHRT (see box), and this may lead to an increase in the number of appeals, which currently stands at approximately 22,000 a year, of which 12,000 are actually heard.

Safeguards for patients on supervised community treatment (SCT)

- A right to appeal to the MHRT when placed on SCT.
- A right to appeal to hospital managers for a review.
- An automatic referral to the MHRT if SCT is revoked and the patient is returned to hospital for treatment.
- The patient's nearest relative has a right to request discharge from SCT (subject to the same restrictions that apply to patients detained in hospital).

As previously reported in the February 2007 issue of Mental Health Today,[1] 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 administration of Tribunal hearings. The aim of the pilot has been to ensure that patients have quicker access to their review hearings and to reduce the number of adjournments and change of date requests that all too often create still further stress for patients, as well as wasting resources.

The interim report[2] set out 12 recommendations, some of which needed to undergo further testing to ensure that they delivered the proposed outcomes. This article describes the findings of those further tests, and the final recommendations that have been agreed with the MHRT Secretariat to ensure that they dovetail with the Secretariat's own improvement schedule.

A number of changes are also being made by the Ministry of Justice (MoJ), following the Leggett review of the tribunal system (see www.justice.gov.uk/docs/tt_consultation_281107.pdf), but these will not affect the right of appeal to the MHRT.

Outcomes from 2007 project

Since the completion of the initial study, many of the recommendations from the original pilot have already been widely adopted. Ethnic monitoring is already happening in hospitals, and will be included in the new IT system that the MHRT Secretariat is commissioning.

The submission of reports via email to the MHRT Secretariat has been implemented by 30% of trusts and a number of independent hospitals, and the MHRT Secretariat continues to encourage all mental health providers to avail themselves of the secure access, which is available at no cost to stakeholders.

The MHRT Secretariat has introduced a new internal system to ensure that teams see the application for an MHRT appeal through to the hearing and, although this initially created some confusion, with the transfer to a single national office in Leicester and a more stable workforce, the benefits of this are already becoming apparent.

The introduction of a booking system for those required to attend MHRT hearings has continued to be operated in the hospitals where this was originally tried, but at that time there was limited evidence to suggest that all trusts should introduce this change.

The improvement plan agreed by the MoJ for the MHRT Secretariat includes minimum standards of accommodation for hearings to take place. The accommodation must be large enough to provide a table for the three panel members and their papers and for five people, including the patient, to be comfortably seated. The layout of the room needs to take into account health and safety implications for those attending. Where →

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Pennine Care NHS Trust

Pennine Care NHS Trust is a specialist mental health trust providing services to people living on the east side of Greater Manchester. We have a Mental Health Act administrator based in each of the five boroughs that the trust serves and process in the region of 1,800 sections and 400 appeals or references to the Mental Health Review Tribunal each year. It has therefore always been a priority to reduce waiting times for hearings and minimise the risk of cancellation or adjournment at short notice.

NIMHE initially asked us to participate in a PDSA that involved contacting solicitors to check their availability for dates prior to contacting the MHRT. However, this system had been introduced across the trust some 18 months earlier, leading to a notable improvement in the booking process. NIMHE then asked the trust to trial the classification process, whereby consultants would be asked to predict the likelihood of the patient still being on section when the Tribunal took place some six to eight weeks later.

The administrators developed a pro-forma to send with the letter to the consultant, notifying them of the appeal and requesting the Tribunal report and asking for the prediction to be returned to the MHA administrator within seven days. The MHA administrator would then forward this on to the Tribunal. Although the system worked well within the trust, it is difficult to comment on any marked improvement with the Tribunal service. The timescale for the implementation of this PDSA coincided with the relocation of the Tribunal service, which may have impacted on the ability of the staff there to fully trial this system.

The trust participated in a second PDSA, in which the ethnicity and gender of patients who were appealing were compared with all those admitted under the Act during the same period. In contrast to the first PDSA, where benefits were not immediately obvious, the gender and ethnicity information has now been included in the trust's activity reports to inform detailed discussion at various committees and forums. The ability to monitor and measure appeals against detentions allows us to identify particular patient groups that may require additional assistance in appealing, or to become aware of cultural differences that may deter a patient from appealing. The trust intends to include this information in future audits of section 132 (information given to detained patients).

A further PDSA that the trust implemented (but did not report on) was the electronic submission of appeal documents to the Tribunal. By using the secure email system, appeals are now processed by emailing the Tribunal office with reports and available dates. This allows monitoring of communications with the Tribunal office and also ensures that documents are delivered in a timely manner. Furthermore, this has resulted in more effective communication between the trust and the Tribunal office. Although this has only been implemented over the last two months, MHA administrators are already reporting that it is working well.

➔ a room is used for other purposes, no equipment is to be left in the room that might pose a risk. Where hospitals use electronic records, access must be provided within the hearing room. A separate interview room for the patient and their legal representative should be available close to the hearing room, and there should also be a waiting area for participants close by. Phone and photocopying facilities should be available for the Tribunal clerk.

Communication between the MHRT and hospitals has improved with the appointment of a communications manager, the introduction of a more stable workforce, and the introduction of IT communication.

The 2008 pilots

In the second stage of the project, some of the proposed changes were piloted in seven NHS provider trusts.

1. Milton Keynes PCT
2. Sussex Partnership NHS Trust
3. Pennine Care NHS Trust
4. South London and Maudsley NHS Foundation Trust
5. Oxford and Buckinghamshire Mental Health NHS Foundation Trust
6. Derbyshire Mental Health Services NHS Trust
7. Avon and Wiltshire MH Partnership NHS Trust

The procedures explored in these pilots were improved communication between the MHRT Secretariat and NHS trusts Mental Health Act (MHA) administrators, and improving the system for booking the necessary personnel (responsible medical officer, solicitors etc) to attend hearings.

The pilots used the PDSA methodology.[3]

- **Plan** – agree the change to be tested or implemented.
- **Do** – carry out the test or change and measure the impact.
- **Study** – study data before and after the change and reflect on what was learned.
- **Act** – plan the next change cycle or plan implementation.

A PDSA cycle involves testing the improvement ideas on a small scale before introducing the whole-scale change. By building on the learning from the test cycles in a structured and incremental way, a new idea can be implemented, with greater chance of success. Reluctance to change is often reduced when many different people/organisations are involved in trying something out on a small scale before whole-scale implementation.

Improved communications

Following the outcome of the 2007 review, it was proposed that classification forms be introduced stating the likelihood that a hearing would actually be required (40% of booked hearings do not actually take place). The intention is that MHRT panels should only be booked by the MHRT Secretariat when they are most likely to be required, thus reducing waste and increasing efficient use of panel members' availability. The classification form asks the patient's responsible medical officer (RMO) to rate the likelihood that the patient will be discharged prior to the Tribunal hearing. The classification would be carried out by members of the clinical team.

The teams involved in this PDSA cycle were able to collect evidence from 277 appeals where the use of classification forms were introduced. The data collected demonstrated that they could be used to predict correctly whether hearings would actually take place in 71% of cases, and that providing this information to the MHRT Secretariat assisted in the advance booking of panel members. In one of the sites, Oxford and Buckinghamshire Mental Health Partnership Trust, this process has been adopted as best working practice and they have not returned to their old way of working.

Booking hearings

This PDSA focused on the difficulties in agreeing dates on which all the necessary personnel could attend a hearing. The frequency of changes of date requests was compounding this problem, and was in large part due to doctors and solicitors being booked separately, by the local MHA administrator and the national MHRT Secretariat respectively.

The key focus of the PDSA was to introduce a booking system whereby the MHA administrator had ready access to the diaries of the responsible medical officers. The administrator would then set dates for hearings and offer them to the MHRT Secretariat.

The data collected in the three sites that participated in this PDSA indicated that, when the trust was responsible for identifying a suitable date for RMOs, solicitors, social workers and attending nurses, and also providing the confirmed date of the hearing to the MHRT Secretariat, the average time spent booking the attendees could be reduced by 37% – from 33.5 minutes (in total) to 21 minutes. The data also suggested that the numbers of change of date requests can be halved when such a booking system is introduced, leading to further savings in staff time.

Moreover, in 100% of cases, the MHRT Secretariat was able to book the panel on the day that the trusts were able to provide it with a date.

Recommendations

Detained patients who wish to appeal against their continuing detention want to be able to have their hearing as soon as possible. This pilot has demonstrated that there are a number of ways that can ensure patients gain speedier access to their MHRT hearings, with fewer adjournments and change of date requests. The pilot has also highlighted the need for appropriate accommodation for the hearings to be held in. The importance of both hospital MHA administrators and the MHRT Secretariat working in a co-ordinated way, where systems are dovetailed to ensure a speedy and reliable booking system, has become very apparent through the course of this improvement pilot. Effective communication between hospital clinical teams and the MHA administration and between the latter and the MHRT Secretariat are paramount in helping to resolve much of the wastage of resources currently encountered.

The findings of the project have been shared with the MHRT Secretariat and the following final recommendations have been agreed.

- Classification of the likelihood of a patient still being detained by the time their hearing is due is a helpful system that should ensure that MHRT panels can be booked as efficiently as possible. It is particularly important that this recommendation is strictly tied in to the booking of hearings, and does not cause delays elsewhere in the system.
- Local MHRT policy should advise solicitors, patients and relatives to inform the MHA administration office as soon as possible of the lodging of any appeal to the MHRT in order for the booking process not to be delayed.
- The current restricted access to RMO diaries needs to be resolved, to reduce the time currently taken to book hearings. The PDSAs found that booking time was dramatically reduced, particularly for RMOs.
- Ethnic monitoring is being undertaken by most hospitals in terms of collecting figures, but there is little evidence of the intelligent use of this data, and the pilot projects were not able to identify and recommend good practice within the timeframe. The MHRT is currently unable to process ethnic monitoring data, but will have this built into their new system. The MHRT will need to establish its own system for the 'intelligent use' of this information – ie. ensure that it informs evidence-based decisions, that services use it to assess their own performance, and that judgements on the quality of care and value for money are based on authoritative information.[4]
- It would be more efficient for the MHA administrator to agree hearing dates with the RMO, solicitor, author of the social circumstances report and nurse. The ultimate responsibility for hearing dates will still rest with the MHRT Secretariat and, wherever possible, it should be the aim of those arranging the hearing date to ensure that two hearings are booked on the same date, to try to maximise the efficiency of the booking system.

We hope that the recommendations from the review will be taken on board so that patients will experience speedier access to their right of appeal and in many hospitals an improved environment is provided that will help to reduce the anxiety that patients may experience. ■

The Mental Health Review Tribunal

The Mental Health Review Tribunal (MHRT) are independent judicial bodies that operate under the provisions of the Mental Health Act 1983 and the Mental Health Review Tribunal Rules 1983. The Tribunal's main purpose is to review the cases of patients detained under the Mental Health Act and to direct the discharge of any patients where the statutory criteria for discharge have been satisfied.

In some cases, the Tribunal also has the discretion to discharge patients who do not meet the statutory criteria. These cases usually involve making a balanced judgement on a number of serious issues such as:

- the freedom of the individual
- the protection of the public
- the best interests of the patient.

Further information available from: http://www.mhrt.org.uk

For the full report and recommendations and further information about the NIMHE Mental Health Act implementation programme, visit http://mhact.csip.org.uk

1 Marsen-Luther Y. Reforming the appeals process. *Mental Health Today* 2007; February: 18–20.

2 Marsen-Luther Y, O'Hare B, Symington J. Interim report on Plan Do Study Act cycles on the recommendations arising from MHRT Improvement Pilot. Hyde: CSIP and NIMHE.

3 Berwick D. Developing and testing changes in the delivery of care. *Annals of Internal Medicine* 1998; 8, 8: 651-656.

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