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Mental Health Review Tribunals

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Following the 1983 Mental Health Act, Mental Health Review Tribunals (MHRT) now provide the opportunity for patients to have their detention reviewed and give a right of appeal against compulsory hospital detention or guardianship (Bluglass, 1983).

Few comparative studies have examined the patients who appeal to the MHRT. This retrospective study examines the social, demographic and clinical variables of a sample of patients who appealed to the MHRT within a specific time period. The question as to whether certain characteristics could predict the outcome of the MHRT is considered. The results of the tribunal's decisions are compared with regional figures.

The study

The study was retrospective in design. It was conducted at All Saints Hospital, a large psychiatric hospital serving an inner city area of Birmingham with a catchment population of over 400,000. The hospital has over 600 beds, with 136 beds for acute admissions, 333 beds for total adult services and 187 for the elderly mentally infirm (EMI). There is also a forensic psychiatry unit on site.

We looked at all appeals to the MHRT from this hospital over 18 months from January 1987 until June 1988. All patients who had appealed to the MHRT during that time were eligible to be included in the study. Their names were identified from a central register of all MHRT appeals. Hospital case-notes relating to all patients thus identified were examined systematically to obtain the necessary information for completion of the study.

The following demographic data were obtained for each of the study subjects from examining their case-notes: age, sex, marital status, ethnicity, subject's living group. In addition, on the basis of the subject's clinical state at the time of his/her appeal to the MHRT, the presence of particular symptoms was established. These covered hallucinations, delusions, formal thought disorder, bizarre behaviour, violence, paranoid ideas and insight. Initial clinical diagnosis during the episode of care prior to appeal was also obtained. Further data covered included the Mental Health Act status of the subject and history of admissions.

The case-notes were also examined for a one-year period subsequent to the MHRT appeal. This provided information about subsequent informal and Mental Health Act admissions, subsequent MHRT appeals including their outcome, subsequent documented convictions and finally the duration of days spent in All Saints Hospital following the appeal.

The decision of the MHRT was obtained from records kept locally for the MHA Commission.

In cases of multiple MHRT appeals, only the first appeal was considered as the index case.

The results were then compared with regional statistics. Analysis involved comparison of MHRT outcome according to the study variables. Both the T-test and the χ^2 test with appropriate Yates correction were utilised in the study.

Findings

During 18 months, 192 individuals were admitted under Section 2 of the Mental Health Act and 65 individuals under Section 3. Only 38 (19.8%) and 7 (11%) respectively appealed against their detentions. All eight patients who were admitted under Section 37/41 appealed to the tribunal.

Out of a total of 52 patients eligible for inclusion in the study, eight had withdrawn their appeals prior to the tribunal. These were excluded from subsequent analysis. On comparing this group (n=8) with the remainder (n=44) it was found that there were no significant differences between both groups. The majority were black (5 Afro-Caribbeans; 2 Asians and 1 white).

The study subjects (n=44) had a mean age of 36 years ±12.4 (range 20 to 73). The age group 20–39 accounted for the vast majority of subjects (81%). The majority were males (75%), over half lived alone under normal circumstances (63%), 55% were white, 36% were Afro-Caribbean and 9% were Asian. A diagnosis of schizophrenia accounted for 70% of the sample. The remainder (20%) consisted of manic depressive psychosis and 10% other diagnoses. Twenty patients (45%) were found to have previous convictions according to their case-notes.

Of the 44 patients heard by the MHRT, 25 (57%) were discharged and 19 (43%) were recommended to remain detained in hospital. Both groups, i.e. discharged (n = 25) and detained (n = 19) were then compared on a number of variables. The results are shown in Table I.

Further information was obtained from the case-notes relating to the above patients. This covered a period of one year commencing from the recommendation date, the results of which are shown in Table II.

Subsequent to the MHRT there was no significant difference in the number of hospital readmissions among the two groups. Three patients (12%) of those discharged were found to have new forensic offences in their case-notes (two were on Section 2 and one on Section 3 at the time of the appeal). There was a significant difference in the number of days spent in hospital after the hearing. Those discharged by the MHRT spent fewer days on average (66 days) than those detained (95 days) at All Saints Hospital.

Comments

The study is limited by the fact that it is a retrospective one. Case-note entries were at times difficult to interpret, highly subjective, or provided insufficient information. However, the available data show that males were more likely to be discharged by the tribunal. No other social, demographic or clinical variable seemed to predict the outcome of the hearing. This is surprising given the numerous variables studied. The diagnosis of schizophrenia, for example, constituted 70% of the sample. Despite this, some 57% of patients were discharged. Studies in other hospitals and regions were compared. A recent study of MHRTs conducted in Leeds (Spencer, 1989) showed similar findings in a comparative sample size (n = 50). However, only 16% of patients were discharged. It is difficult to draw conclusions by comparing both studies due to differences in the composition of samples. The Leeds sample, for example, contained more females, Section 3 patients and more diagnoses of manic depressive psychosis.

Another report from a London hospital (Roberts & Rogers, 1989) would appear to confirm that only 20% of those heard by the MHRT were subsequently discharged.

This study's findings are not consistent with this trend, nor are they consistent with those of the region. The London Office for the MHRT reports that 19.8% are discharged (excluding Broadmoor). Figures from the Liverpool Office show a higher proportion of 36% discharged in the West Midlands.

More detailed comparisons with the West Midlands figures (Liverpool MHRT) tend to show a higher proportion of MHA admissions to All Saints Hospital. About 12% of all admissions per year are

TABLE I

Comparisons between detained and discharged groups on a number of variables at the time of the MHRT hearing

Variables	Detained group (n = 19)	Discharged group (n = 25)
Mean age:	35.8 ± 10.4	36.1 ± 14.8
Sex*:		
Males	11 (58%)	22 (88%)
Females	8 (42%)	3 (12%)
Marital status:		
Single	13 (68%)	17 (68%)
Married	3 (16%)	3 (12%)
Divorced/separated	3 (16%)	5 (20%)
Living group:		
Alone	13 (68%)	15 (60%)
Spouse/Partner	3 (16%)	3 (12%)
Family	3 (16%)	6 (24%)
Unknown	—	1 (4%)
Ethnicity:		
White	11 (58%)	13 (52%)
Afro-Caribbean	6 (32%)	10 (40%)
Asian	2 (10%)	2 (8%)
Clinical picture:		
Hallucinations/Delusions	13 (68%)	21 (84%)
Violence	6 (32%)	10 (40%)
Paranoid ideas	8 (42%)	7 (28%)
No insight	10 (52%)	15 (60%)
Diagnosis:		
Schizophrenia	13 (68%)	18 (72%)
Manic depressive psychosis	5 (26%)	4 (16%)
Miscellaneous	1 (5%)	3 (12%)
Mental Health Act status:		
Section 2	12 (63%)	16 (64%)
Section 3	4 (21%)	4 (16%)
Section 37/41	3 (16%)	5 (20%)

*$P < 0.05$

TABLE II

Follow-up of both detained and discharged groups for 1 year subsequent to MHRT hearing

Variables	Detained group (n = 19)	Discharged group (n = 25)
Number of informal admissions	3 (16%)	6 (24%)
Number of Mental Health Act admissions	6 (32%)	8 (32%)
Subsequent forensic history	None	3 (12%)
Mean days in hospital subsequent to MHRT*	95.2	66.6

*2-tail $P < 0.05$

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MHA sections as opposed to 7.8% at the regional level (Korner Return, 1990). There is also an excess of Section 2 and restricted hearings in our study when compared to non-special hospitals (after correction for special hospitals which skew the overall pattern) (Liverpool MHRT, 1987, 1988). Various causes may be responsible for the higher proportion of MHA admissions, hearings and MHRT discharges in the index hospital. Increased psychiatric morbidity within the catchment area is a possibility. Rough comparison between the Jarman Scores (Jarman, 1983) for all the districts in the West Midlands region shows that West Birmingham (one of the two districts served by All Saints Hospital) has a Jarman score of 45, by far the highest in the region, with Sandwell, the second district, scoring only 11.

Another possibility is the prominent forensic practice at All Saints Hospital. The presence of a forensic unit will skew the results. It is interesting to note that three patients discharged subsequently broke the law within the following year. None were previously on restriction orders prior to their tribunal hearings. None of those detained did so. Nevertheless, disregarding all eight restricted patients from our sample would still produce a figure of 56% discharged by the tribunal.

In addition to the above variations in the patient population, differences in professional practices may be present. For example, there may be a higher tendency of psychiatrists using the MHA sections. This would explain the higher proportion of both MHA admissions and hearings but not discharges. Alternatively a more efficient appeal system within the hospital and/or variations in the decision-making processes of the tribunals could explain the higher proportion of both hearings and discharges respectively.

The tribunal's decisions were unaffected by the remaining sociodemographic and clinical features. It is likely that there were other criteria considered by the tribunal, e.g. assessment of patients needs, or those of his family (Hoggett, 1984), premorbid personality and the concept of dangerousness (Home Office & DHSS, 1975; Hamilton & Freeman, 1982; Bowden, 1985) which is based on past events in an attempt to predict expected behaviour in the future. All these variables and others, impossible to measure in this study, could have had significant impact on MHRT decisions.

We recommend that in future studies the reasons given by the MHRT for their decisions to discharge or detain patients should be analysed. In this study these reasons were often so briefly documented as to be meaningless. Similarly, the analysed clinical features obtained from case-notes were relatively crude. The legal criteria on which cases are judged are quite specific and relate to relevant clinical conditions at the time of the tribunal. They are not well defined in clinical terms and this lack of definition may be responsible for some of the variance between hospitals, regions and tribunals. Future studies may need to address issues such as the presence of mental illness at the time of the tribunal and whether it is of a nature or degree warranting hospital detention and if so whether this is for reasons of health or safety or the protection of others. Finally, future studies should include data on whether the patient was represented by a lawyer at the tribunal hearing.

In practice, there is wide variation in the style in which MHRT hearings are conducted. Further comparative studies are necessary. A cross-sectional approach and controlled studies may reveal interesting regional and/or national trends both in psychiatric morbidity and in our own application of the 1983 MHA.

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