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Who can best protect patients' rights?

The Mental Health Act (MHA) 1983 created three tiers: national, regional and local, for protecting the rights of patients under section, the Mental Health Act Commission (MHAC), the mental health review tribunals (MHRTs) and the hospital managers. Although the Act was in many ways revolutionary, there have been a number of criticisms about the structures it created.

National

The MHAC, while a well respected and competent body, is hampered by the fact that it is remote; commissioners can only visit establishments caring for sectioned patients once or twice a year. It lacks any power to compel provider units to follow good practice and can only 'name and shame' in its biennial reports. It cannot review complaints unless they have not been satisfactorily settled by hospital managers. It has no power to discharge patients from section, nor does it concern itself with the treatment of voluntary patients.

Regional

The only two avenues of appeal against continued detention are the MHRTs and the managers. The MHRTs have a statutory duty to hear appeals and to review sections at certain mandatory periods. Lack of resources, especially in terms of clinical and administrative personnel, makes it impossible for the tribunals to meet demand in a timely way. As a result, there are long delays before patients' appeals are heard, which is a serious erosion of their rights. The largely professional make-up of the tribunal is often seen as intimidating by patients, who may suspect collusion between the professions or a reluctance to challenge the opinion of another psychiatrist.

The tribunal remit is very narrow, concerning itself primarily with the legality of the section, and not with more holistic issues such as the appropriateness of treatment.

Local

Hospital managers have overall responsibility for ensuring that the powers and duties of the Act are lawfully obeyed. While the power to discharge from section is shared between the MHRT, the responsible medical officer (RMO), the nearest relative and the managers, it is the managers alone who have the power to detain. There is a clear logic in giving the power to discharge to those in whose name the detention is made.

There has been much criticism, largely anecdotal, of hospital managers. Accusations of inappropriate discharge are not substantiated by a review of incidents, where the fault more commonly lies with lack of coordination between the relevant agencies. The *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness* (Department of Health, 1999) makes no reference to bad decisions by managers, nor does it make any recommendation to abolish the power of discharge. The expert group tasked with taking forward the Scoping Study has recommended that the hospital managers' power to discharge patients should be discontinued, but it offers no reasons. Neither does the Minister, in accepting that recommendation in the Green Paper (Department of Health, 1983), outline any benefits or reasons for the decision. Significantly, this decision is not offered up for consultation.

Why weaken the managers' role?

It is disturbing that those who advocate the abolition of managers' power to discharge have not articulated clear reasons or demonstrated the benefits from so doing. The announcement by a former Secretary of State for Health, Steven Dorrell, to abolish this power merely stated that:

> "The role of the MHRTs is clearly defined in the Act but the Managers' role is much less explicit. The existence of two completely separate systems can create confusion for patients and duplication of effort. I do not believe that a dual system is necessary or that there is a valid role for lay managers in this area." (Dorrell, 1996)

Support for this view was also expressed by the Council of Tribunals, giving as their reasons:

> "confusion at all levels between the role of Managers' Reviews and MHRTs, not least in the mind of patients, the uncertainty among managers as to their powers and the inconsistency of approach as to who should take part in the review process and how it should be conducted".

Confusion and duplication of effort can be overcome and managed. These are not good enough reasons for

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removing managers' power in this respect. If MHA administrators and ward staff do their job properly when informing sectioned patients of their rights, there should be no confusion. It is interesting to note that although Chapters 22 and 23 in the new *Code of Practice* (Department of Health and Welsh Office, 1999) are dedicated to the hospital managers' duties and power of discharge, there is no reference to the right to appeal to managers in Chapter 14, which details information that must be given to patients.

Benefits of hospitals' managers

The very real benefits that managers can bring stem from the fact that they are both local and lay people. Living and working locally, it is possible to arrange hearings with speed. Professor Rolf Olsen quotes the gold standard achieved at the trust where he was a non-executive director as being 5 days from lodging the appeal (personal communication, R. Olsen, 2000). More realistic for the majority of trusts would be between 1 and 2 weeks. This compares well with the MHRT delays of 8 weeks and more. The panel members, being lay people, bring a common-sense attitude to bear, which is reassuring for the patients and carers. They are able to ask the simple questions about care and treatment that the patient may wish to ask, but sometimes is not able to – questions that might not occur to the professionals working in the service. There is the opportunity not only of putting the patient more at ease, but also of obtaining a better understanding through the potential to convene a panel whose members could reflect age, gender, ethnic origin or religion of the patient. The current wording of the Act encourages a holistic approach to the care and treatment offered. Managers concern themselves with issues of medication, side-effects, polypharmacy, prescribing within *British National Formulary* levels and consent to treatment. They also look at Section 17 leave, whether the patient has worries about housing, personal belongings, personal finance, visiting or has problems on the ward. In other words, reassurance about everything and anything that any parent, child, spouse or carer would want to have about the treatment of a loved one.

The removal of the managers' power to discharge patients from section would completely undermine the present role and would remove the safeguards and benefits they currently bring into the system.

At a mental health conference last year, William Bingley, Chief Executive of the MHAC spoke despairingly about the inability of the Commission to compel compliance with the Act by consultant psychiatrists. In the Scoping Study consultation meeting in London on 29 April 1999, many speakers voiced fear and suspicion of consultants. The amendments to the 1983 Act identified the chairman and non-executive directors of the trust as hospital managers, creating a powerful tool to ensure compliance by all staff.

If an appeal or renewal hearing is being chaired by the trust chairman, reports are prepared in a timely way and staff make every effort to attend hearings. It is possible over time to persuade the professionals that managers' hearings are a useful process in a non-adversarial setting in which to test their practice, just as non-executive director involvement in board meetings is a healthy way for executive directors to judge the validity of their propositions.

Consultants in Kingston have expressed an appreciation of the value of this process as it is seen to help them in their decision-making. It is also worth recording that in Kingston in every case where managers have discharged against medical advice, the RMO and the multi-disciplinary team have subsequently agreed with the legality and validity of the action taken.

Equally importantly, the managers, whether the trust chairmen, non-executive directors or associate directors, learn a great deal about the realities of the service they provide. This information is an essential aid to improving patient services and supporting staff.

The thorough process of a manager's hearing, the testing of evidence and clarification of professional views, is a very important part of risk management. Increasingly relevant in a world that has become more and more litigious, a robust hearing gives confidence to the trust board and should be seen as helpful and supportive to staff in that it provides a powerful protection from potential future legal action. This process could form an important part of the clinical governance agenda.

By using lay people, the system taps into a far larger and cheaper resource than is available to the MHRTs because most associates are voluntary workers (some trusts pay a nominal honorarium). A proactive, well-regulated recruitment process can ensure an adequate supply of suitable people to take on the task. The key is to implement a robust, open and competitive recruitment and appointment process; to give thorough training in the Act at the point of recruitment; to demonstrate good practice; and to maintain training throughout the period of appointment. There should also be monitoring and supervision of individuals and regular performance reviews.

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