Mental Health Review Tribunals in the UK:

Applying a Therapeutic Jurisprudence Perspective

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Judges and other legal personnel, understandably, have a profound interest in the impact of their decisions on all those who come in contact with the law. Naturally, the outcomes of court decisions, whatever their specific context, are of enormous importance to all individuals concerned. But in recent years there has been a growing recognition that legal processes in themselves, including the ways in which courts and judges interact with citizens, also have significant impacts on people before a tribunal or court. Indeed, Tom Tyler has reviewed evidence that the most influential features of legal practices upon individuals are not "objective characteristics of the case disposition experience," but rather "their assessment of the fairness of the case disposition process."[1]

The study described in this article is concerned with the perceptions of the decision-making processes of the Mental Health Review Tribunals in England and Wales. We have interviewed members of tribunals charged with reviewing decisions on detention as well as patients who have appeared before those tribunals. The study analyzes disparate perceptions of tribunal procedures emanating from the two sets of interviewees with the purpose of understanding how those procedures might be made more effective. Understandings gained from this study provide a basis for recommending reforms to law and practice and judicial behavior that promote the psychological and physical well-being of those affected by tribunal proceedings and decisions.

In searching for an intellectual framework within which to locate the research, the perspective of therapeutic jurisprudence appeared to offer the kind of analytic approach required, together with the possibility of affording particularly valuable insights. Therapeutic jurisprudence, the study of law as a therapeutic agent,[2] provided a foundation that was both conceptually and ethically inter-linked with the research aims of this study, which include expanding upon previous research and re-establishing a dialogue on the merits of the tribunals, and providing an impetus for procedural improvements for tribunal clients.

In this study, a primary focus of interest is upon the impact of legal processes on the individuals who use them or who are subject to them. One possibility raised by this is that in some cases, legal procedures that are designed to safeguard an individual's rights might in reality be anti-therapeutic. If these procedures are identified, it is incumbent on us to be aware of their impact, and to address the necessary steps that could enable more appropriate changes to be introduced.

LEGAL BACKGROUND OF MENTAL HEALTH REVIEW TRIBUNALS IN THE UK

Like most other countries, the United Kingdom has a special set of laws concerned with the management and care of persons with severe mental disorders.[3] In England and Wales, patients with a defined mental illness or personality disorder who are thought to pose a risk to themselves or others can be compulsorily detained in hospital. The rules that govern such detention are defined by the 1983 *Mental Health Act* (MHA).[4] This states that patients who meet certain criteria in respect of mental disorder and dangerous behavior can be placed under sections of the MHA (colloquially, "sectioned"); patients sectioned can then be confined for varying amounts of time in secure hospital units.

The level of security involved may vary considerably. The majority of patients made subject to these conditions are held in environments such as locked psychiatric wards in district general hospitals; there are wards of this type in local hospitals in most parts of the country, each housing a small number of patients only. Others may be hospitalized in purpose-built "medium secure" units; each administrative health region has

Footnotes

1. T. R. Tyler, *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings, in* LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE 6, 7 (D. B. Wexler & B. J. Winick eds. 1996)[the book hereafter referred to as LAW IN A THERAPEUTIC KEY].
2. D.B. WEXLER & B.J. WINICK, ESSAYS IN THERAPEUTIC JURISPRUDENCE (1991); and LAW IN A THERAPEUTIC KEY, *supra* note 1. *See also* J. Mcguire, *Can the Criminal Law Ever Be Therapeutic?*, 18 BEHAV. SCI. & LAW., in press (2000).
3. Though we have referred here to the United Kingdom, which includes England, Wales, Scotland, and Northern Ireland, specific acts of legislation may sometimes apply to only one or other of these divisions of the realm. The most significant aspect of this from a legal perspective is that the Scottish system has its own traditions that are distinct from those in the remainder of the UK, and its administration is largely separate. In this essay, however, we are focusing primarily on the situation of the Mental Health Act (1983), which covers England and Wales only.
4. Mental Health Act (England and Wales) (London: Her Majesty's Stationery Office). The MHA is accompanied by a *Code of Practice*, which sets out policies to be followed in respect of a number of key aspects of its operation.

one unit of this type, and their capacity generally varies between 30 and 70 beds. For a proportion of persons who are assessed as presenting the most serious risk, detention may be indeterminate. Such individuals are generally placed in maximum security institutions, familiarly known as the "Special Hospitals." There are three such hospitals in England: Broadmoor (founded in 1863), Rampton, and Ashworth, altogether housing approximately 1,700 patients, many of whom have committed homicides and other of the most serious types of crimes.

Broadly speaking, there are two kinds of sections, or commitments, that can be imposed under the MHA. The first are known as the "civil" sections and, in essence, their usage depends on decisions made by medical practitioners without reference to courts of law. The length of detention that results from implementing these procedures can vary from 28 days to 12 months and longer. The second type includes a range of measures taken by the criminal courts, which may make what is known as a *Hospital Order* (MHA section 37) requiring that the individual in question be detained in hospital for treatment. In a proportion of cases, this order may be further strengthened through imposition of a *Restriction Order*.

When committed to a facility under one of the MHA sections, the patient's care is managed and many aspects of his or her welfare are decided by the *Responsible Medical Officer* (RMO), who, as this title implies legally, is responsible for the patient's care. The RMO is a consultant psychiatrist; this role is itself specified in one of the sections of the MHA. While he or she will typically have the support of, and work alongside, a multidisciplinary team, the RMO's recommendations based on his or her assessments of patients play a pivotal role in influencing how long patients remain in the hospital and whether or not they should be discharged.

There is, however, a purportedly corrective or countervailing power alongside this. Under another MHA provision, the patient has the right to question the legitimacy of his or her detention and can apply to *a Mental Health Review Tribunal* (MHRT) in order to have this issue assessed. The tribunal provides an independent hearing and consists of a three-member panel—respectively, one legal, one medical, and one lay member. The legal member is chairperson or *president* of the tribunal and may be a solicitor (attorney), though, with patients who are detained with restrictions, this may be more likely to be a circuit judge. The medical member is usually a psychiatrist who is independent of the hospital where the patient is detained, and who also interviews the patient beforehand as well as during the tribunal hearing. The lay member, customarily, is not entirely lay in that he or she is likely to have a background in social or community issues. Although tribunal hearings are generally less formal than courts of law, patients are usually represented by a solicitor (attorney). This is not always the case (some patients choose to represent themselves) and the patient may or may not attend the hearing. In effect, other members in attendance become witnesses; they include the RMO, a social worker, possibly a psychologist who has provided therapy for the patient, and the patient's relatives. The overall function of the process is to act as a check on whether the patient continues to meet the legal and medical criteria for detention under the MHA.[5] If this is found not to be so, the tribunal may order the patient to be discharged.

[L]egal procedures that are designed to safeguard an individual's rights might in reality be anti-therapeutic.

PRIOR RESEARCH

This article's focus is the working of the Mental Health Review Tribunal, and in what follows we describe how a tribunal is experienced and perceived respectively by patients and tribunal members.[6] To prepare the ground for this, let us first consider available research on the functioning of MHRTs. Very little research has sought to evaluate the role of the tribunal. The major exception is the work of Jill Peay,[7] who conducted an extensive project during the 1980s on the operation of the tribunal and made a number of astute observations. Sadly, neither subsequent policy departures nor research studies have furthered her recommendations. Her research examined two elements of the MHRT's role: first, the impact of the MHA on the tribunal's work (MHRTs had existed prior to the 1983 passage of the MHA); and second, the MHRT's decision-making process.

In her study, Peay used a variety of methods to gather information. These included semi-structured interviews with tribunal members and analysis of case records. She found that patients described a number of concerns, particularly over relationships with their RMO. Patients were disgruntled by erroneous statements written about them in reports prepared by their doctors, and they were unhappy with the overall level of contact they had with their RMOs. Patients valued the role of the tribunal, but not necessarily for the purposes for which it was originally designed. They emphasized the opportunity to state their concerns regarding their hospital care, and to hear what staff had to say about their progress.

Peay concluded that the difficulties expressed by patients were worrying, particularly when they talked about their relationships with their RMO. The RMO's opinion is a crucial factor in whether a patient is detained or discharged. If patients felt that they did not receive adequate time and care, then a true picture of their progress might not be represented at the

5. R. Jones, MENTAL HEALTH ACT MANUAL (4th ed. 1994).
6. Further details of this research can be found in the following paper, which is currently being submitted for publication. N. Ferencz and J. McGuire, *Patient's Experiences of the Mental Health Review Tribunal* (1999).
7. J. Peay, *Mental Health Review Tribunals: Just or Efficacious Safeguards?* 5 LAW AND HUMAN BEHAVIOUR, at 161-186 (1981); J. Peay, *Mental Health Review Tribunals after the Act: A Significant Improvement?* 4 ISSUES IN CRIMINOLOGICAL AND LEGAL PSYCHOLOGY, at 37-46 (1983); J. Peay, *The Mental Health Act 1983 (England and Wales), Legal Safeguards in Limbo*, 14 LAW, MEDICINE AND HEALTH CARE at 180-189 (1986); J. Peay, TRIBUNALS ON TRIAL: A STUDY OF DECISION-MAKING UNDER THE MENTAL HEALTH ACT 1983 (1989).

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tribunal. Furthermore, she found that the tribunal itself often concurred with the RMO's recommendation. In 84% of their decisions, tribunals were found to agree with the recommendation made by the RMO; this led Peay to question whether the tribunal was actually prepared to exercise its discretionary discharge powers.

MHRTs have received little attention from researchers during the last ten years. However, a small number of investigations have thrown light on several aspects of the tribunal's functioning. This work includes analysis of reports presented to tribunal hearings,[8] examination of the difficulties that tribunals face as a result of delays and resultant costs,[9] and descriptive work concerning the patients who use MHRTs.[10]

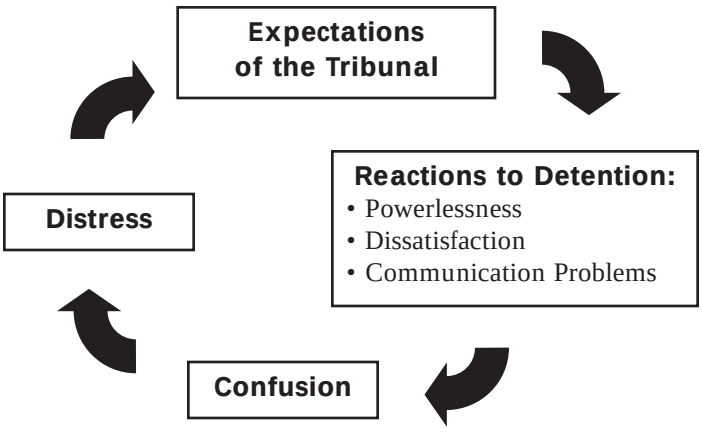
THE PRESENT STUDY

The studies listed above focused on specific aspects of the functioning of the tribunal. There is no research that furthered the earlier concerns expressed by Peay or evaluates the tribunal's role. In the present study we attempted to address some of the issues raised by Peay and to investigate what patients, judges, and other tribunal members think about the tribunal today. Given these objectives, the present study needed to be exploratory and it was decided that a mixture of qualitative (e.g., interviews) and quantitative (e.g., systematic analysis of the interview contents) methods would be used in order to meet the research aims.[11] Those aims were to investigate the experiences of patients who had recently attended their MHRT hearing and to investigate tribunal members' views of the MHRT itself. The main method employed was interviewing; interviewees were chosen using a purposive sampling method and all interviews were tape-recorded, as required by established interviewing techniques.[12] For the patients, the interview began by asking them to describe their most recent tribunal experience. Tribunal members, too, were asked to describe a recent tribunal experience.

RESEARCH FINDINGS

Patients and MHRT members demonstrated a number of differences in how they viewed the tribunal procedure. Patients described a number of key themes, which tended to fall into two categories: reactions to their detention in general; and specific reactions to the tribunal experience. Similar, overlapping themes occurred in both categories and patients described a "cycle of distress," which typically begins when they enter hospital. This cycle appears to be perpetuated by the tribunal process (see Figure 1).

FIGURE 1: THE CYCLE OF DISTRESS



Furthermore, patients' expectations of the tribunal appeared to be correlated to their tribunal experience. Understanding the elements of this cycle of distress provides critical insights for improving outcomes for patients through improved tribunal procedures.

A major, and in many ways pre-eminent, theme described by patients was the degree of communication difficulty they experienced with their care staff and with the tribunal.

8. P. Davidson and A. Perez de Albeniz, *Reports Prepared for Mental Health Review Tribunals*, 21 PSYCHIATRIC BULLETIN at 364-366 (1997); B. Brockman, *Preparing for Mental Health Review Tribunals: Reports and Dilemmas,* 17 PSYCHIATRIC BULLETIN at 544-547 (1993).
9. C. A. Kaplan, *Mental Health Review Tribunals and the Council on Tribunals*, 19 PSYCHIATRIC BULLETIN, at 438-441 (1995); S. Blumenthal and S. Wesseley, *The Cost of Mental Health Review Tribunals*, 18 PSYCHIATRIC BULLETIN at 274-276 (1994); S. Blumenthal and S. Wesseley, *The Pattern of Delays in Mental Health Review Tribunals,* 18 PSYCHIATRIC BULLETIN at 398-400 (1994).
10. K. F. G. Saad and S. P. Sashidharan, *Mental Health Review Tribunals,* 16 PSYCHIATRIC BULLETIN at 470-472 (1992). These authors reviewed a series of patients who applied for tribunals over an 18-month period. They concluded that the only variable that was related to outcome was gender.
11. Seventeen patients and ten tribunal members agreed to take part in the study. A combination of content analysis and grounded analysis was employed to complete a sequence of steps designed to identify emergent themes in the responses made by patients and MHRT members respectively. [For further information on content analysis, *see* K. Krippendorf, CONTENT ANALYSIS: AN INTRODUCTION TO ITS METHODOLOGY (1980); on grounded theory, *see* B. G. Glaser and A. L. Strauss, THE DISCOVERY OF GROUNDED THEORY: STRATEGIES FOR QUALITATIVE RESEARCH (1967).] First, interview data was transcribed and a content analysis was conducted. The data were also analyzed qualitatively in order to identify any recurring themes. Second, the emerging themes were used as a template for two interviews in order to test out the generated themes. Both authors conducted this process independently and some modifications were made to the classification system. Next, the themes were analyzed so that any linkages between them could be identified. Fourth, agreement ratings were generated between the two authors' use of the classification system. As a separate component of the analysis, similarities and differences between responses from patients and members to the 15 key statements were analyzed using statistical tests.
12. For discussion of these sampling and interview approaches, *see* M. Q. Patton, HOW TO USE QUALITATIVE METHODS IN EVALUATION (1987).

Characteristic statements included:

> The tribunal—they weren't even interested in it, I didn't get my say.
>
> They wouldn't let me talk, tell my side of the story. They were listening to all the others first.
>
> Well, I thought they'd listened to me a bit more than they did do. I would have thought they would have done [more].

Patients appeared to feel alienated from proceedings that were designed as an independent review of their detention status:

> They're so old, I felt like I was at school . . . . They were quite out of touch, they seemed to say things were minor and they were little things when I don't think they were.
>
> Yes you can get confused at a tribunal because they speak amongst themselves. It is like a trial really.

There were, of course, conflicting views expressed, both between members and patients, and amongst members themselves. Members differed in how well they thought patients understood what was happening in the tribunal. Also, they differed in the extent to which they believed that they gained an accurate picture of the patient. Eight out of ten tribunal members said that they were happy with the tribunal. All of those interviewed, however, did describe some problems. These included, for example, a dislike of specific hearings and of how independent reports were used, the need for further training, the wish for feedback concerning patients' subsequent progress, and difficulties with RMOs.

Finally, the results from the rating scales were investigated by conducting significance tests on the average scores for members and patients. These results demonstrated two interesting findings. First, patients showed more variability in their replies than did members (their ratings covered a significantly wider range). Second, there were statistically significant differences (e.g., differences unlikely to be the product of chance factors) between patients and tribunal members on several of the scales. Thus, for example, patients were significantly less likely than MHRT members to agree that the MHRT is an independent body. Also, patients were significantly less likely to agree that the tribunal was fair. These results demonstrated that there are important differences between how patients and tribunal members view the tribunal process, with tribunal members demonstrated a more favorable view.

CONCLUSIONS

The results strongly suggest that patients and MHRT members have quite different views of the tribunal process. There may be a marked need, therefore, for patients to have more education about the role of the tribunal and of its functioning and operation. Patients feel that they have not been heard and that their concerns have not been recognized. Communication needs to improve between staff, tribunal members, and patients so that the cycle of distress described by patients can be addressed.

These findings are consistent with and provide further support for the conclusions of other researchers who have examined similar issues. Jack Susman,[13] in a study of conflict resolution in hospitals, found psychiatric patients were "very concerned with receiving fair process" in resolving disputes, and they were certainly capable of discerning the degree of fairness of procedures regardless of the actual outcome for themselves. Such findings underscore a fundamental principle of the therapeutic jurisprudence perspective. In a study with objectives similar to the present one, Alexander Greer and his colleagues[14] interviewed patients involved in civil commitment hearings and found they reported distress and felt they had "little or no voice" in the proceedings. Their perceptions of the legal process appeared inter-linked with their general experiences of treatment in hospital, marked in most cases by a lack of trust in their doctors.

The therapeutic jurisprudence approach helps to draw our attention to these experiences and provides a basis for seeking to remedy these concerns. The proposals of Wexler and Winick,[15] that the role of law must receive attention when its practice proves to be anti-therapeutic, are thought to be particularly relevant to these tribunals. This approach also questions whether a biomedically oriented viewpoint should be paramount in our understanding of and response to mentally disordered offenders; it stresses the potential importance of psychosocial information when guiding the treatment of patients with mental health difficulties. Congruent with this viewpoint, recent research on prediction of recidivism by James Bonta and his colleagues[16] suggests that the reliance on the medical features of a mental disorder presentation is unfounded; demographic and criminal history variables prove to be better predictors. Furthermore, mental illness diagnoses were found to be unrelated to (indeed, negatively correlated with) recidivism. This would suggest that a psychologist's or a social worker's report could provide better evidence in helping the tribunal to make a decision. The comments of one tribunal member clearly indicated that the former type of evidence is under-valued:

> The medical [evidence] is crucial, the medical evidence is decisive. I am not going to decide a case on a probation report or a social work report and you sometimes get social workers who step out of their role and become the advocate for the defendant and pronounce

13. J. Susman, *Resolving Hospital Conflicts: A Study on Therapeutic Jurisprudence*, *in* LAW IN A THERAPEUTIC KEY 907.
14. A. Greer, et al., *Therapeutic Jurisprudence and Patients' Perceptions of Procedural Due Process of Civil Commitment Hearings, in* LAW IN A THERAPEUTIC KEY 923. Patients reported feeling "angry, sad, displeased, and confused" and had a sense of being "coerced." *Id.* at 930.
15. *See supra* note 2.
16. J. Bonta, et al., *The Prediction of Criminal and Violent Recidivism Among Mentally Disordered Offenders: A Meta-Analysis*, 123 No. 2 PSYCHOLOGICAL BULLETIN at 123-142 (1998); and *see* J. McGuire, *Commentary on the Efficacy and Effectiveness of Community Treatment Programs in Preventing Crime and Violence in Those with Severe Mental Illness in the Community by Kirk Heilbrun and Lori Peters*, PREVENTION OF CRIME AND VIOLENCE BY MENTALLY DISORDERED OFFENDERS (S. Hodgins and R. Muller-Isberner eds. 2000).

> on psychiatric matters… we have to decide this case on criteria of dangerousness and I am not having this from a social worker as to whether somebody is safe.

Tribunal members appeared to be sensitive to the needs of patients. However, they demonstrated inconsistencies in their actions and described many different approaches for dealing with their difficulties. As with any public service, there needs to be some analysis of how the tribunal system operates as a whole. This analysis should focus on how the tribunal discharges its role. The tribunal system is an independent body that was designed to safeguard the rights of patients who had been detained. Disagreements between tribunal members and patients, therefore, require attention and patients' concerns need to be properly addressed. Analysis of the tribunal could take the form of an internal audit of procedures so that problems can be identified and solutions generated.

Members were willing to listen and were eager to receive feedback about their actions. It is recommended that patient follow-up statistics be tabulated and maintained so that members would receive information about their actions. Furthermore, this process could be incorporated into a wider training program that would support tribunal members and move towards identified goals that recognize the provision of good service. This would mean that good practice could be extended and that practice that fell below such standards could be eliminated.

Finally, further research is needed to continue the focus on the functioning of the Mental Health Review Tribunal. This should address both the difficulties for patients as well as tribunal members and could be extended to review of the entire tribunal procedure. Monitoring of any procedure is imperative so that individuals' rights can be safeguarded and necessary improvements made. If the process entails difficulties, then these deserve attention within the provision and funding of mental health services. If they cannot be adequately addressed, then attention needs to focus on why, and whether the tribunal system in its current format can actually fulfill its designated functions.[17]

Nicola Ferencz is a clinical psychologist working in a medium security mental health unit in Stafford, England. She obtained her doctorate qualification in 1998 and completed the current research as part of her degree. The study has uncovered many important issues regarding the impact of the tribunal process upon patients' mental health. Her current aim is to continue to explore this area and to increase public and professional awareness of these issues.

James McGuire is director of studies of the doctorate in clinical psychology training program at the University of Liverpool in England. He is a chartered clinical and forensic psychologist and carries out assessment of offenders for criminal courts and Mental Health Review Tribunals. He has conducted research in prisons, probation services, adolescent units and secure hospitals on aspects of the effectiveness of treatment with offenders. He is the author or editor of eight books and more than 70 other publications. He is currently conducting a number of research projects on the development, implementation, and evaluation of cognitive skills training programs.

17. The last major review of law pertaining to mentally disordered offenders was that undertaken by the Butler Committee in 1975 (Home Office/Department of Health and Social Security, *Report of the Committee on Mentally Abnormal Offenders [The Butler Report])* (1975)(Cmnd. 6244. London: Her Majesty's Stationery Office). There followed an eight-year gap before some of its proposals were enacted in the present Mental Health Act (1983). In comparative terms, by those standards, the pace of change at the present moment is little short of breathtaking. In July 1999, the government published a new set of proposals for the management of persons with severe personality disorders (Home Office/Department of Health, *Managing Dangerous People with Severe Personality Disorder: Proposal for Policy Development* (1999)(London: Her Majesty's Stationery Office). Only four months later, in November 1999, a second consultation document was published, the product of a specially commissioned expert committee. (Department of Health, *Reform of the Mental Health Act 1983: Proposals for Consultation* (1999)(Cm. 4480. London: Her Majesty's Stationery Office). At the time of writing, responses have been invited to this consultation document, with a submission deadline of March 31, 2000. A centerpiece of the proposals is the establishment of a new kind of independent tribunal or decision-making body, the precise model for which has yet to be determined. This group would have powers regarding admission to hospital, the issue of orders for compulsory treatment, and review of detention.