Mental Health Tribunals: Examining current practice, rising caseloads and future reform

REPORT

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The author alone is responsible for this report.

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EXECUTIVE SUMMARY

This report results from a one-day policy seminar in December 2017 - Mental Health Tribunals: Evaluating Current Practice and Moving Forward - funded by the University of Manchester and The UK Administrative Justice Institute (UKAJI). The seminar explored the following issues: (i) what are the drivers for increasing detention rates under the Mental Health Act 1983? (ii) what challenges face mental health tribunals with rising caseloads? And, (iii) what is the future for mental health tribunals?

The seminar was attended by 30 people from: central government departments; the UK Administrative Justice Institute; tribunals; clinicians; Independent Mental Health Advocates (IMHAs); in addition to representatives and academics with expertise in mental health. The project was sponsored by two external partners: UKAJI and HM Courts and Tribunals Service.¹

The seminar discussion unveiled the complexity of the issues. The tension between improving efficiency within the mental health tribunal system while also maintaining a robust system of checks and balances to protect the vulnerable. It is important to have an effective system that works well and produces just outcomes. At the same time, there are practical limitations, such as limited resources and information deficits. This poses a range of challenges that require some trade-offs and compromise.

The report offers some reflections as to why use of the Mental Health Act 1983 is rising, particularly given the policy shift towards and reinforcement of community focussed care following the Mental Health Act 2007. The report also considers the inextricable link between mental health legislation usage and the tribunals system. It draws upon the shared learning found within the seminar discussion to

¹ This report contains the author’s views alone and does not represent those of HM Courts and Tribunals Service or UKAJI.
identify key issues that may be encouraging this trend, while also identifying aspects of the system that work well.
Mental illness costs the UK economy £100 billion a year. In 2012, HM Government spent £126 billion on health, and pledged to spend a further £400 million on psychological therapies and mental health care provision for children and young people. Mental health needs remain acute and have garnered further support and promise for support in the years to come. Following the 2017 Autumn budget £6.3 billion of extra NHS funding was announced, of which £2.8 billion will be poured into day-to-day health services and £3.5 billion in new buildings and equipment. However, given the demands on the NHS and acute sectors overall, concerns remain that there will be little additional money for mental health care.

This funding picture provides an important backdrop for considering how the mental health legislation is deployed when responding to serious mental health support needs. The Mental Health Act (MHA) 1983 provides the legal framework which governs decisions made concerning the care and treatment of those suffering from mental disorder where they may pose a risk to themselves or others. The legislation sets out the circumstances when mental health professionals can make decisions about detention and/or treatment without the patient’s consent.

The conflicting perspectives of the patient and the care provider are often the source of tension and challenge within mental health law. On the one hand, the Act

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3 HM Treasury, Budget 2011, London, TSO, March 2011, HC836, chart 1
seeks to provide a workable system of checks and balances to ensure robust and justifiable decisions are made. Ensuring the interests of patients are well-served is an important and fundamental driver. Yet, situated at the heart of the legislation is also the need to protect others from potential harm. Getting the balance right remains a primary goal. Navigating through the minefield of conflicting interests is difficult.

Getting this right has become even more crucial since the Human Rights Act 1998 which requires UK compliance with the European Convention in Human Rights. Articles 3, 5, 6, and 8 play a central role within the mental health law sphere. Article 3 provides the right not to be subjected to torture or to inhuman and degrading treatment or punishment. Article 5 provides a right to liberty and security except on defined and discrete grounds. Article 6 provides a right to a fair and public hearing that is both timely and independent. Article 8 provides a right to respect for private and family life unless interference is justified as a proportionate response to a legitimate reason.

Detention is allowed under Article 5 ECHR when there is evidence of ‘unsound mind’ and it is this which has so far provided justification for the mental health legislation currently in place. As long as a patient meets the Winterwerp criteria, detention will be lawful. The patient must reliably be shown to be of unsound mind; the mental disorder must be of a kind or degree warranting confinement; and the validity of the confinement depends on the persistence of the mental disorder. These criteria must be met in every case.

Winterwerp also laid down guidance concerning the patient’s right to challenge his current detention. There must be transparency and legal certainty. The detention criteria must be ‘in accordance with a procedure prescribed by law,’ set out in legislation that can then be scrutinised in court. A patient detained under the MHA 1983 is provided with this and access to a mental health tribunal offering the

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apparatus to review and challenge detention. This right to review was first established under the MHA 1959 and has since been amended and refined with further amendments introduced by the MHA 1983 and the MHA 2007.

The mental health tribunal hearing seeks to provide an informal, inquisitorial, and supportive atmosphere. They are usually held in private at the hospital which is detaining the patient with an adjudicatory panel of three (presiding lawyer, medical and lay member). A separate space should be provided for a patient to confer with her legal representative. A review application triggers the writing of various reports from hospital managers, the Responsible Clinician (RC) the Approved Mental Health Practitioner (AMHP), relevant nurses, psychologists etc, which are usually provided to the patient and the panel. Patients are able to obtain an independent medical report.

Access to and timing of a tribunal hearing depends upon the nature of the detention. The detention rates of these different categories will necessarily impact upon overall tribunal caseload and the level of pressure exerted upon the tribunal system. Patients whose detention is subject to restrictions face a different review timeframe to those patients whose detention, whether civil or criminal, is not subject to restrictions. Restrictions refer to s.41 patients; those detained ‘during her Majesty’s pleasure’; those acquitted on the grounds of insanity, and those found unfit to plead. Only one application to the tribunal can be made during ‘the relevant period’ which, for them, is between six and twelve months of the court disposal and once a year thereafter. The Home Secretary must refer a case if the patient is a detained patient whose case has not been considered in the

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8 Section 66, Mental Health Act 1983 outlines when the patients or his nearest relative may make and application to the mental health tribunal.

9 A patient can be sectioned under several different parts of the legislation for assessment or to receive treatment for a mental disorder. Part II of the Act deals with the civil commitment provisions. These are the sections that do not involve the criminal law and include section 2 (for assessment), section 3 (detention for treatment), section 4 (emergency detention), and, sections 5(2) and 5(4) (holding powers). Part III of the Act deals with the forensic sections. They deal with patients who have been involved in criminal proceedings and include section 35 (remand to hospital for report), section 36 (remand to hospital for treatment), section 37 (hospital order), section 38 (interim hospital order), section 47 (transfer of sentenced prisoner to hospital), section 48 (removal to hospital of unsentenced prisoners), section 47/49 (transfer from prison to hospital with restrictions), section 48/49 (removal to hospital of other prisoners with restrictions), section 37/41 (hospital order with restriction) and section 41 (the conditionally discharged patient).
previous three years; a patient who was unfit to plead and did not make a referral in the first 6 months; or, a conditionally discharged patient who is recalled to hospital and the case must be referred within one month of recall.

For unrestricted patients, only one application can be made during ‘the relevant period’ which differs depending upon the nature of the patient’s detention or circumstance giving rise to the application. For section 2, admission for assessment, the application must be made within 14 days of admission. For section 3, admission for treatment the application must be made within six months of admission. Following renewal of detention, applications to the tribunal can initially take place within the first six months, then every twelve months thereafter. Review following transfer from guardianship to hospital must take place within six months and for hospital orders, review applications can be made between six and twelve months of order and then every twelve months. The tribunal system is placed under particular strain as a result of the tight processing time for section 2 patients.

This report argues that the increased caseload of mental health tribunals is an inherent consequence of increased detention under the Mental Health Act 1983. Detention rates under the mental health legislation have been rising and this has been a consistent trend over the last decade. This has had a knock-on effect upon tribunal applications. To understand how to best reduce the caseload of mental health tribunals, it is necessary to determine the factors that influence initial entry into the system. The reasons behind accelerating formal detention rates under the Mental Health Act 1983 are complex, and often multi-factorial. Each patient and their needs are unique and the clinical and social response reflects this.

This report offers some reflections on the operation of mental health tribunals and the drivers for its increasing caseload. It draws on the shared learning and experiences of some of the people involved in the care, treatment and support of mentally ill people and those involved directly in the legal process designed to support and protect them.
CHAPTER 2

DETENTION RATES UNDER THE MENTAL HEALTH ACT 1983

2.1. Introduction

The number of people detained under the Mental Health Act 1983 is rising exponentially – a trend that has been continuing for the last decade. Some 63,600 people were detained under the MHA 1983 in 2015/16 compared to 43,400 in 2005/06 - an increase of 47%. The 2015/16 detention figure is the highest it has been since 2005/06 when 43,361 detentions were recorded.

![Chart showing detentions from 2011/12 to 2015/16.](source)

Specifically, detentions under Part II of the Mental Health Act 1983, that is section 2 admission for assessment and section 3 admission for treatment, have seen particular rises from over 28,500 in 2011/12 to nearly 39,000 in 2015/16 (nearly a 27% increase). For section 2 detentions alone, there has been a rise of nearly 32% between 2011/12 and 2015/16.
These increases have occurred at a time when both mental health and social care provision continue to experience significant financial challenges. With austerity continuing to bite, mental health provision has not always received the attention it deserves with physical health needs dominating resource allocation. However, mental health conditions account for 23 per cent of the total burden on the NHS, but only 13 per cent of NHS spending is directed towards psychiatric and related services. This under-investment is not new and despite funds being channelled through Primary Care Trusts at a regional level to recognised areas of need prior to the Health and Social Care Act 2012 and now through Clinical Commissioning Groups (CCGs) following the 2012 Act, resource shortfalls continue. Mental health, commonly referred to as the ‘Cinderella’ service, has been struggling under the weight of systemic neglect for a considerable time. Mental health care must compete with all other health and social care needs, of which most are far more evident and positive post-treatment outcomes more easily quantified.

Source: NHS Digital, Inpatients formally detained in hospitals under the Mental Health Act 1983 and patients subject to Supervised Community Treatment: 2015/16, Annual figures, November 30, 2016
The needs associated with mental ill-health have been explicitly recognised for some time. In 2011, a new mental health strategy was published, *No Health Without Mental Health: a Cross-Government Mental Health Outcomes Strategy for People of All Ages*,\(^\text{10}\) followed by an implementation framework which sought to reinforce mental health as a key priority. The strategy aimed to provide better mental health for all and to increase the likelihood of recovery, while the implementation framework focused on the provision of strong outcomes monitoring. In the Health and Social Care Act 2012, these mental health objectives were mapped onto the NHS restructuring process. The 2012 Act sought to do this by explicitly recognising that mental ill-health should be given parity alongside other physical health needs.

Despite these efforts to reinforce the need to support mental health provision, mental health continues to experience the effects of low funding and underinvestment compared to its physical health counterparts. Identifying and understanding the source of this underinvestment has proven difficult. CCGs have underinvested in mental health services relative to physical health services. However, the degree of the disparity has largely been obscured by the way spending on mental health conditions is grouped together and reported, unlike spend on physical health care, which is disaggregated by specific conditions. Spending per capita across CCGs varies almost two-fold in relation to underlying need. The social care system is also under sustained and growing pressure, with significant real-terms cuts in spending resulting in a reduction in the number of people accessing publicly funded care.\(^\text{11}\)

In 2016, the pressure placed upon the NHS was recognised. The provision of universal, high quality healthcare remains a steadfast commitment, but the way in which the NHS operates to meet this requires change to accommodate the modern-day context. In 2016, NHS England published a report, *Five Year Forward View for Mental Health*, which identified key recommendations to improve both


the experience of health care and overall outcomes. The report identifies key changes that necessitate a radical rethink around healthcare provision. Notably, a central aspect of the strategy is the recognition that steps need to be taken to respond to increasing inflexibility within the NHS. This impedes the way in which health care provision is undertaken and the creation of artificial barriers often stymy effective policy and practical implementation. Successful joint working between different facets of the NHS has been hindered – of interest to this report is the gap between physical and mental health has become ossified over time.

Modern day mental health care emphasises the view that more people when carried out in the least restrictive way.\textsuperscript{12} The more traditional interpretation of this notion focuses around keeping people out of hospital and in the community as often as possible and providing the support needs required. In practice, this has not always been easy to achieve in terms of providing the levels of community-based support needed. However, understanding that patients are much more likely to have a better outcome if allowed to stay within a familiar home environment while accessing support networks is universally accepted. It is also acknowledged that when patients do have to go to hospital, and require formal detention, the experience is less traumatic and more likely to have a positive outcome when a patient is detained locally.

Data suggests that achieving this is increasingly difficult. Sending people out of area for acute inpatient care as a result of local bed pressures has become a spiralling problem and is having a negative impact upon the way in which mental health care operates and how patients experience their care.\textsuperscript{13} In its report, The Five Year Forward View for Mental Health, the Mental Health Task Force

\textsuperscript{12} Mental Health Act Code of Practice (p 22): one of the five overarching principles is least restrictive option and maximising independence. In essence this means that where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. See also at a global level, World Health Organisation, Mental Health, Human Rights & Legislation: Denied Citizens, Including the Excluded. Available at: www.who.int/mental_health/policy/legislation/2_HRBasedMH Laws_Infosheet.pdf. Accessed 18\textsuperscript{th} April 2011.

\textsuperscript{13} See, NHS Digital, Out of Area Placements in Mental Health Services Data Quality Statement 2017, October 2017.
recommended round the clock community-based mental health crisis care available in all areas across England and adequately resourced intensive home treatment to reinforce the emphasis upon non-inpatient care when appropriate and to reduce increasing reliance on out of area placements.\textsuperscript{14}

There are complex underlying reasons behind the increase in detention. The causes may differ from one area to another. Furthermore, the legislative landscape surrounding the provision of mental health care, support for the vulnerable and the provision of care both within hospital and in the community, can be fraught with uncertainty.

\textbf{2.3. Rising use of section 2}

An area for concern is the increased use of section 2. This section authorises the compulsory admission of a patient for the purpose of assessing the patient’s mental condition. Section 2 also allows for medical treatment to follow assessment. Treatment under this section\textsuperscript{15} has the same scope as that found under section 3. However, the power to detain is time limited for up to 28 days. Consequently, section 2 may be used in practice as a way of providing short-term treatment.

Section 2 requires admission for assessment may be made in respect of a patient on the grounds that—

(a) he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and

(b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.

\textsuperscript{14} The Mental Health Taskforce, \textit{The Five Year Forward View for Mental Health A report from the independent Mental Health Taskforce to the NHS in England}, February 2016.

\textsuperscript{15} Section 145 MHA 1983 (as amended) states that ‘medical treatment’ includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care.
In *R v. Wilson, ex parte Williamson*,\(^\text{16}\) the court emphasised the importance of using the appropriate section to detain a patient. Section 2 use should only be for a short duration and for a limited purpose. It should be used to assess a patient’s condition to determine whether treatment would be effective and whether a section 3 application would be an appropriate next step; yet, the data suggests that section 2 is being used well beyond these narrow remits.

There are several reasons for the increased use of section 2. The provision is thought to assist with access to mental health services. The availability of beds has decreased and bed shortages are resulting in delayed admission. With bed occupancy rates in inpatient facilities being well above recommended levels, use of voluntary admission as a preferred method of entering the mental health system is being hampered by scarce resources. Where a patient is deemed in need of care in hospital, resort to civil commitment may be the quickest means of opening up services. The bed occupancy data for all mental health overnight beds was largely stable throughout 2017, though demonstrated a significant overall decline. Across England there is were just over 18,000 beds available. In 2015/16 mental health beds for overnight use were in the region of 22,500. This accounted for a 20% drop in available beds between 2015 and 2017. In 2001, 34,214 overnight beds were available for use. This represents a 47% reduction of mental health beds since 2001.

\(^{16}\) [1996] COD 42.
Mental health inpatient bed occupancy is frequently well above recommended levels. Community care facilities and services, particularly crisis resolution and home treatment teams that often deal with acute care needs, struggle to provide sufficient levels of support to compensate for bed scarcity. This is creating intense pressure on both hospital and community services and is having a negative impact on safety and quality of care.\(^\text{17}\) Furthermore, the lack of available local beds is leading to higher numbers of out-of-area placements for inpatients. When beds are unavailable locally patients are being transferred to facilities outside their area.

The Care Quality Commission has highlighted the extent of the problem. In 2012/13 over 4% of adult emergency admissions were out of area. In some areas, reliance upon out of area beds is particularly widespread and has meant journeys of more than 300 miles for some patients. Moving patients out of their area and away from family and support networks has been found to have a negative impact upon the patient’s experience. For patients with a bed on an acute ward, the

environment may not always be safe or therapeutic, or conducive to recovery. While for those waiting for a bed because of bed shortages, any lack of early intervention or crisis care support may worsen their health forcing a decision to move them out of area in order to secure a bed.

Another area of concern believed to be directly impacting upon formal detention rates is the role of inequalities and cognitive bias in decision making. Data from 2016/17 illustrates that people within a broad Black ethnic group were more likely to be detained under the Mental Health Act 1983, with those from the Black Caribbean group having the highest rate of detention of all ethnic groups. Work is currently being undertaken to understand why these differential rates of detention are taking place.  

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**Fig. 4**

![Graph showing rates of detention (per 100,000) under the Mental Health Act 1983 by specific ethnic groups.](http://content.digital.nhs.uk/mhsds)

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**2.4. Declining community support and its impact**

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18 The *Mental Health Act: independent review* is currently underway, chaired by Professor Sir Simon Wessely, a former President of the Royal College of Psychiatrists, and is due to be reported on by autumn 2018. One particular area of work led by the African and Caribbean working group will examine the experiences and perspectives of black people in relation to the mental health legislation.
A further factor that has influenced the increasing use of the civil commitment procedures under the Mental Health Act 1983 is the decline in contact patients experience when in the community.\textsuperscript{19} Evidence supports the view that a key component of a successful community care experience is the presence of strong family and social networks for the individual concerned.\textsuperscript{20} Lintern's work suggests that with less support in the community, the safety net these services provide is inadequate to meet needs.\textsuperscript{21} Keeping patients out of acute crisis becomes increasingly difficult and a factor in the rising numbers of detentions. With real term cuts in funding by the NHS on mental health, access to care outside of acute provision has become more difficult.\textsuperscript{22} For example, assertive outreach provision as part of traditional Community Mental Health Teams has suffered significant funding cuts.\textsuperscript{23}

Without sufficient funding to support community-based care, accessing services for patients has required greater reliance on formal hospital detention provisions. However, the inpatient data suggests that entry into the mental health system for many continues to be through section 2. Unless the criteria for section 3 admission for treatment are met, most patients will be discharged within 28 days. For many patients, this brief window of time is enough to stabilise their condition and allow for continued good health in the community.

\textsuperscript{19} Care Quality Commission, Monitoring the Mental Health Act in 2015/16, London, CQC, 2016.
\textsuperscript{21} S. Lintern, 'Mental health charity funding falls as demand grows,' Health Service Journal (2012) 31 May.
\textsuperscript{22} A. McNicoll, 'Mental health trust funding down 8% from 2010 despite coalition's drive for parity of esteem', Community Care, (2015) March 20; S. Lintern 'Analysis reveals mental health trust funding cuts,' Health Service Journal (2014) 14 August. See also, Care Quality Commission, Right here right now: people’s experiences of help, care and support during a mental health crisis, London: Care Quality Commission, 2015.
However, for others, as the Care Quality Commission suggest in its report - *Monitoring the Mental Health Act in 2015/16*; increasing detention rates may have been affected by the rise of revolving door patient numbers. These are patients who often experience repeated involuntarily hospitalisations. However, trying to determine the extent to which inpatient data includes revolving door patients is difficult. The data is not sufficiently nuanced; it does not demarcate the nature of the admission, past psychiatric history and community care experience. Constructing an accurate representation of patients entering the mental health system under the Mental Health Act 1983 is therefore problematic.

Revolving door patients have been an ongoing problem. Community Treatment Orders (CTOs), introduced under the Mental Health Act 2007, were an attempt to respond to the challenges presented by this patient population. However, further questions have been raised about the potential correlation between rising detention rates and the introduction of CTOs. Whether Parliament should introduce a regime of supervised community treatment in England and Wales was a long-standing question, which began with the decision in *R v Hallstrom*, *ex p W*. The CTO (also known as ‘Supervised Community Treatment’, or SCT) authorises community-based supervision of compulsory patients following their discharge from hospital. A patient discharged onto a CTO must comply with the conditions of the order or face recall to hospital.

Arguments against CTOs have largely centred on civil liberties, public protection and the professional legitimacy of care and treatment providers. It appears that as long as ‘the practice is properly regulated, its criteria, procedures, and powers are clearly specified by law, it makes proper use of medical expertise, and it

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25 [1985] 3 All E R 775.
26 Community treatment provision under the 2007 Act is referred to as ‘supervised community treatment’ but the 2007 Act refers to the legal mechanism giving effect to it as a ‘community treatment order’.
27 Section 17A-17G, Mental Health Act 1983.
28 Section 17B(3)(a), Mental Health Act 1983.
applies in a proportionate manner supervised community treatment will not violate a patient's human rights. The strongest argument in favour of supervised community treatment holds that it serves as a mechanism for a continuous system of care allowing effective transition between hospital and community care. This framework for long-term community care was thought to reinforce rights and responsibilities for both users and providers of this service.

Despite the anticipated benefits associated with CTOs, evidence suggests that these have yet to materialise. The result of the Oxford Community Treatment Order Evaluation Trial (OCTET), undertaken in 2012 suggests that CTOs have not reduced the rate of readmission to hospital as compared with the use of section 17 leave. In 2011/12, there were 4,220 CTOs in operation. By 2015/16 this was 4,361. The early expectation was that CTO use would gradually increase over time assuming that these community-based provisions would enable a formal shift away from in-patient mental health care. The impact assessment for the Mental Health Act 2007 projected NHS savings of approximately £34 million per year by 2014-15 assuming that 10% of section 3 admissions would instead be placed under supervised community treatment. The data tells us that the

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32 See, K v Craig [1998] UKHL 54, which discussed the benefits that can flow from a community-based programme of care. This case considered these issues in relation to the earlier system of supervised discharge which was introduced by the Mental Health (Patients in the Community) Act 1995. This regime has since been repealed.
36 Section 17, Mental Health Act 1983 provides for leave of absence from hospital for patients who are currently liable to be detained in a hospital.
37 Full datasets for community treatment order usage can be found at: https://www.digital.nhs.uk/search?q=community+treatment+order&s=s
expectation around patterns of decision making behaviour have not changed radically with detention figures continuing to rise.

2.5. The Cheshire West effect (and other cases...)

The Supreme Court in *P v Cheshire West and Chester Council; P & Q v Surrey County Council* [2014] UKSC 19 (‘Cheshire West’) clarified an ‘acid test’ for what constitutes a ‘deprivation of liberty.’ The outcome of this case has significantly lowered the threshold for the engagement of Article 5 ECHR. The acid test states that an individual is deprived of their liberty for the purposes of Article 5 ECHR if they: lack the capacity to consent to their care/treatment arrangements; are under continuous supervision and control; and are not free to leave. All three elements must be present for the acid test to be met.38

This case raised several fundamental questions around the concept of physical liberty and what is needed to both protect this and ensure detention is legitimate. A vital question addressed by the cases was whether the concept of physical liberty protected by article 5 is the same for everyone, regardless of whether or not they are mentally or physically impaired. Linked to this was a second question, around what the essence of deprivation of liberty was, and what could be permissible and non-permissible deprivations of liberty under article 5. In determining whether the acid test was met, the court held that it was irrelevant if the person concerned complied or simply did not object. Furthermore, the relative normality of the placement was irrelevant as was the reason or purpose behind a particular placement. Key to this policy driven decision was the recognition that the position of extremely vulnerable people needs to be subject to independent periodic checks.

The ruling in Cheshire West had significant practical implications. Data published by the Health and Social Care Information Centre (HSCIC) confirmed that, following the Supreme Court judgment, in the first year, Deprivation of Liberty

38 The Court of Protection has held that the acid test also applies in acute non-psychiatric hospital settings. See, *HS Trust & Ors v FG* [2014] EW COP 30.
orders (DoLS) applications rose approximately ten-fold. In 2013/14 there were approximately 13,700 applications. In 2014/15 there were 137,540. Of these, 62,645 applications were completed by local authorities during the year, almost five times as many as in 2013-14.\textsuperscript{39}

The immediate increase in applications had a number of repercussions. The extra activity for health and care providers was significant: increases in the number of DoLS authorisations prepared and submitted, higher Court of Protection applications and local authority teams were required to respond to more requests to assess authorisations and where appropriate, authorise any deprivation of liberty. The significant increase in requests for authorisations, resulted in many local authorities left struggling to process these within the legal time limit.

For mental health patients, the repercussions of \emph{Cheshire West} have also been felt. The broader impact of the decision has reinforced a cautionary approach to be adopted by clinicians. Section 131 MHA allows the informal treatment of patients with their consent.\textsuperscript{40} Looking at the data around informal patient numbers, a stark shift is evident following the \emph{Cheshire West} decision. The number of informal patients in psychiatric facilities reduced while formal detentions increased. In 2008/09, there were 75,843 informal patients, while there were 30,913 formally detained patients. By 2014/15, the balance between these two categories of patient had shifted considerably, with 51,196 informal patients and 54,225 formal patients.\textsuperscript{41} This suggests that post-\emph{Cheshire West} health and social care providers and decision-makers may be much more sensitive now to the risk of unauthorised deprivation of liberties and this has consequently had a knock-on effect upon formal detention rates.

The impact of ‘risk’ as a more nebulous construct has also been felt in recent years in the mental health care field.\textsuperscript{42} Historically, risk has always featured prominently

\textsuperscript{39} For the full statistics, see, \url{https://digital.nhs.uk/catalogue/PUB17509}.
\textsuperscript{40} BUT does not allow deprivation of liberty - \emph{HL v UK 45508/99}.
\textsuperscript{41} \textit{Mental Health Minimum Data Set / Mental Health and Learning Disabilities Data set and Hospital Episode Statistics}, NHS Digital; Office for National Statistics.
\textsuperscript{42} For a wider discussion on how risk is used to define and regulate activity in several areas, see C. Hood, et al, \textit{The Government of Risk Understanding Risk Regulation Regimes}, Oxford, OUP, 2001.
in mental health care. Following the Mental Health Act 2007, risk assessment and management have become the explicit concerns of the civil commitment process. It reflected policy-makers concerns that ‘the safety of both the individual patient and the public are of key importance in determining the question of whether compulsory powers should be imposed’ and that this was not sufficiently the focus of the mental health legislation prior to the 2007 Act amendments. For that reason, ‘concerns of risk [began to take]...precedence’.

Mental health decision-makers must seek to achieve a balance between their patients’ personal freedoms and the public’s safety. Risk provides a mechanism (albeit a problematic one) with which decision-makers may achieve this balance, by deploying the compulsory powers under the Mental Health Act where a patient’s level of risk becomes so great that he/she poses a threat to either him/herself or others. The standards which the compulsory criteria require are ambiguous. Decision-makers enjoy a wide discretion to interpret relevant factors according to their professional judgment. Sections 2(2)(b) and 3(2)(b) presume that decision-makers will assess a patient’s level of risk. Risk is an open-ended construct for decision-makers to assess and interpret according to their professional judgment and experience.

Rose argues that the language of risk seems ‘all-pervasive’ in contemporary mental health practice. This is unsurprising: risk determines the nature, duration and extent of a patient’s engagement with the mental health services. Similarly, a patient’s risk profile determines the nature, duration and extent of his/her supervision in the community. Yet mental health decision-making has

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47 See, e.g., 1983 Act (as amended by the 2007 Act), sections 20 (duration of authority) and 23 (discharge of patients).
always entailed an element of risk assessment.\textsuperscript{49} Successive legislative frameworks have reflected this practical reality, albeit in a fairly oblique manner. Consequently, a patient’s risk either to him/herself or others always plays a significant part in the decision to engage the civil commitment procedures.\textsuperscript{50} While soft law, such as the Code of Practice and generic NHS Trust Clinical Risk Assessment Tools,\textsuperscript{51} provide some guidance, what constitutes a risk to a patient’s health or safety or to others is a matter for decision-makers alone. How reliable, valid and professionally rigorous risk assessments remains open to question.\textsuperscript{52} Bartlett contends that some decision-makers may find themselves operating in a system driven by personal experience with a fairly \textit{ad hoc} system of interviewing and determination.\textsuperscript{53}

Therefore, concerns around risk in terms of understanding what it is, how to assess it and manage it accurately and effectively remain a central feature of mental health care practice. Behavioural responses to this have also been shaped by external influences, of which the \textit{Cheshire West} case is one. Two further cases involving the assessment of suicide risk have also had an impact upon risk and its management regarding clinical decision-making. In \textit{Savage v. South Essex Partnership NHS Foundation Trust}\textsuperscript{54} failures to take reasonable precautions to protect the lives of patients with suicidal thoughts was found to have violated Article 2 ECHR.\textsuperscript{55} In \textit{Rabone v. Pennine Care NHS Foundation Trust}\textsuperscript{56} the Court held

\textsuperscript{49} Castel defines risk management as ‘the identification, assessment, elimination or reduction of the possibility of incurring misfortune or loss’. In his view, risk has ‘become an integral part of the professional responsibility of all those involved with psychiatry’. See, R. Castel, ‘From Dangerousness to Risk’, in G. Burchell, \textit{et al}, \textit{The Foucault Effect: Studies in Governmentality}, Harvester Wheatsheaf, 1991.
\textsuperscript{50} Mental Health Act \textit{Code of Practice}, paras 4.6, 4.7.
\textsuperscript{52} M Grann \textit{et al}, \textit{Psychiatric Risk Assessment Methods: Are Violent Acts Predictable? A Systematic Review (Summary and Conclusions)} 2005; SBU Report No 175. This suggests that the inaccuracy of psychiatric assessment methods is in the range of 25 to 30 per cent.
\textsuperscript{54} \textit{Savage v South Essex Partnership NHS Foundation Trust} [2008] UKHL 74.
\textsuperscript{55} The state has a responsibility to protect an individual’s right to life and the law reflects such a position. Article 2 of the European Convention on Human Rights, states that, “everyone’s right to life shall be protected by law”.
\textsuperscript{56} \textit{Rabone v. Pennine Care NHS Foundation Trust} [2012] UKSC 2.
that the operational duty\textsuperscript{57} to protect life could be owed to informal psychiatric patients as well as formally detained patients under the Mental Health Act 1983\textsuperscript{58} as long as there has been ‘an assumption of responsibility by the State for the individual’s welfare and safety (including by the exercise of control)’.\textsuperscript{59} The European Court also agreed that the duty could be owed to an informal patient.\textsuperscript{60}

The practical impact of these cases is noteworthy. Health services must ensure high professional standards are met and effective systems of work are in place.\textsuperscript{61} The recognition of the operational duty to protect the life of a specific individual in cases of suicide risk where it is known or should have been known that there was a ‘real and immediate risk of suicide’\textsuperscript{62} has reinforced the obligation placed upon health care professionals. Given the acknowledged difficulty surrounding accurate risk assessment,\textsuperscript{63} an issue that was highlighted in \textit{Rabone}, both \textit{Savage} and \textit{Rabone} present significant implications for public bodies who assume responsibility of vulnerable people.

The effect of \textit{Cheshire West}, \textit{Savage} and \textit{Rabone} has led to greater sensitivity to risk and the potential repercussions should something go wrong. When there is doubt or uncertainty, it is now more likely the civil commitment provisions in the Mental Health Act 1983 will be seen as the best option and use of informal hospitalisation will be less attractive.

\textbf{2.6. The rise in section 136 use}

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\textsuperscript{59} \textit{Rabone v Pennine Care NHS Foundation Trust} [2012] UKSC 2, at p 22.
\textsuperscript{60} \textit{Reynolds v United Kingdom} (2012) 55 EHRR 35.
\textsuperscript{61} \textit{Powell V United Kingdom} (2000) 30 EHRR CD 362.
\textsuperscript{62} \textit{Keenan v United Kingdom} (2001) (Application no. 27229/95). It should be noted that a risk of harm, even serious harm would be insufficient. For the risk to be real it must be objectively verified, and for it to be immediate, it must be present and continuing (\textit{Re: Officer L} [2007] UKHL 36).
Police in England and Wales are provided under section 136 of the Mental Health Act 1983 with powers to remove a person to a place of safety or to keep a person in an existing place of safety where it is believed the person needs to be examined by a doctor and interviewed by an AMHP. Police are required to make an assessment of individuals found in a public place who appear to be suffering from symptoms of mental illness. The purpose of any section 136 assessment is to determine whether a person ought to be detained in hospital under the Mental Health Act. 64

Although there is a presumption that resort to the Mental Health Act should be a last resort, a shift in the use of section 136 by the police is apparent.

Fig. 5

<table>
<thead>
<tr>
<th>Year</th>
<th>Section 136 Rates</th>
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<tbody>
<tr>
<td>2011/12</td>
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<tr>
<td>2012/13</td>
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<td>2013/14</td>
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<td>2014/15</td>
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<tr>
<td>2015/16</td>
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Source: NHS Digital, Inpatients formally detained in hospitals under the Mental Health Act 1983 and patients subject to Supervised Community Treatment: 2015/16, Annual figures, November 30, 2016.

64 Following the recent changes to section 136 MHA 1983 by the Policing and Crime Act 2017, police powers will extend beyond the public place and can now be used anywhere that is not that person’s private home. The requirement of being found has been removed, so someone may be kept at a police station potentially where they are no longer liable to be detained under the Police and Criminal Evidence Act 1984. A registered medical practitioner, registered nurse or approved mental health professional must be consulted with, if practicable before removing someone to or keeping them at a place of safety under this section. These changes provide further opportunities for section 136 to be used.
More notably, the shift in section 136 reliance has impacted on conversion rates. With the presumption that section 136 should only ever be used if no other avenues were available, conversion rates from section 136 to section 2 and section 3 were high. Since the early 2000s, conversion rates were in the region of 85% suggesting that the police were primarily putting people on a section 136 who warranted informal admission to hospital. Those taken out of a public place by the police were highly likely to need mental health support. However, the *Cheshire West* decision discouraged use of the informal patient status under section 131. The increasingly heavy use of section 136 is likely to have an impact on section 2 and 3 figures. Since 2014, conversion rates from section 136 to both section 2 (29% increase since 2014) and section 3 (32% increase since 2014) have risen. However, drawing a firm conclusion that the *Cheshire West* decision has had a marked and direct effect on conversion rates is difficult given the presence of multi-factorial drivers, though it has certainly played a significant role.

**Fig. 6**

![Conversion rates from section 136 to sections 2 and 3](image)

Source: NHS Digital, Inpatients formally detained in hospitals under the Mental Health Act 1983 and patients subject to Supervised Community Treatment: 2015/16, Annual figures, November 30, 2016.

This data suggests a number of things. First, the use of section 136 has gone up as has the conversion rate from section 136 to sections 2 and 3. Therefore, there is a direct bearing upon overall detention figures and consequently tribunal receipts. Second, evidence suggest that revolving door patients are being identified by
police and section 136 is being used. Third, the Care Quality Commission’s concern that community-based services are becoming increasingly fragmented with more gaps forming in service provision may be requiring greater input by the police. Finally, concerns around patients either not being able to access mental health services when they need it or being discharged too quickly because of overstretched acute care services, may be leading to more vulnerable people on the streets which the police are having to identify and support. This data provides a useful insight into the fragile nature of the contemporary mental health system and impact of this on mental health tribunal activity.

2.7. Can detention rates be reduced?

Several things might relieve some of the pressure on the system. Reducing reliance on section 2 would significantly free up the mental health care system and create space in the corresponding review process. As discussed above, several factors influence the heavy use of section 2. Some of these factors, such as the rising use of section 136, have arisen because of broader policy and funding changes to the mental health system and so are not easily fixed. Ensuring that section 2 is used only for mental health assessment purposes would reduce the availability of the section for a considerable number of patients. Strengthening the Mental Health Act Code of Practice might be an initial way forward. Likewise, the practical demands placed on clinicians wishing to detain a patient under section 3 could also be modified to enable access to care via section 3 possible. Currently, it is necessary to identify inpatient facilities for patients to be detained under section 3. Given tight budgets and fluid resources, it is not always possible to do this.

Clinicians often detain individuals under section 2 to allow breathing space for inpatient beds to then be sourced. The impact of this is twofold. Patients are not placed on the appropriate care pathway that their condition demands, and the deployment of section 2 instead of section 3 instigates two review processes

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65 Care Quality Commission, Right here right now: people’s experiences of help, care and support during a mental health crisis, London, CQC, June 2015, p 77.
instead of one. The tribunal system is taken up by patients that would have been better served by appropriate sectioning in the first instance. However, problems around resources require more than one step system fixes.

While gaps remain elsewhere in the mental health and social care system, it is unlikely that a more literal interpretation of section 2 admission criteria would necessarily help. Those not admitted under section 2 (as they do not just require assessment) but for whom services are not available for them under section 3, may simply find themselves picked up elsewhere in the system, such as under section 136. Better communication, local joint protocols and joint working in terms of procurement and delivery between different agencies and stakeholders would, however, be beneficial.67

The seminar revealed the complexity of the issues and the constraints facing clinical decision makers in determining the best course of action for their patients. At the same time, it also uncovered some of the systemic difficulties in terms of meeting the challenge of mental health with limited resources.

3.1. Rising caseloads

The upsurge in inpatient detention under the Mental Health Act 1983, has clear and direct implications for tribunal caseloads. Between 2007/8 and 2016/17, tribunal receipts increased from nearly 22,000 to over 33,000 receipts – a rise of over 33%.


Section 2 cases have increased by around 32%, though this also reflects the rising volume of section 2 detentions (a rise of nearly 32% between 2011/12 and 2015/16). Looking at data published by the Care Quality Commission, section 2 related tribunal activity increased overall between 2014/15 and 2015/16. Section 2 applications increased from 9,729 in 2014/15 to 10,093 in 2015/16.

68 For a detailed breakdown of activity in the First-tier Tribunal (Mental Health), see, Care Quality Commission, Care Quality Commission, Monitoring the Mental Health Act in 2015/16, London, CQC, 2016, p 51.
while hearings increased by over 7%. Section 2 discharges made by tribunals dropped by approximately 1.5% over the same period.69

Increased tribunal workloads present significant practical challenges. Section 2 review applications, in particular, have raised specific problems. Hearings must be listed within 7 days of application, and undertaken within 14 days of the date of admission. With the pressure on time and mounting demands to make effective and efficient decisions, the increasing number of section 2 applications have meant that mental health tribunals have had to manage this while maintaining standards. Ensuring effective decision-making may be affected by the level of information, data and supporting documentation available at the hearing. The short timeframe to prepare a case may result in the quality and depth of the accompanying responsible authority reports being compromised.70 There may have been insufficient time for the clinical team to be in a position where a judgement can be made about the patient’s current mental state. Treatment options may not have had enough time to provide an indicative picture of potential success. For many cases, writing a report about a patient for whom the clinical team still knows little will be difficult. Added to this is the often-chronic demands for reports to be produced quickly and at short notice. With insufficient information, projected treatment outcomes unknown and little time for the patient to settle, both the clinical team and tribunal panel are faced with a decision-making situation that is fraught with difficulty and necessarily encourages a cautious approach. For the tribunal system, increased caseloads also mean more judicial sittings and increased demand on limited judicial resources.

The increased use of detention powers by hospitals and increased tribunal caseloads has downstream cost implications especially for the Ministry of Justice.

70 See, Practice Direction First-Tier Tribunal Health Education and Social Care Chamber Statements and Reports in Mental Health Cases, October 2013. This provides details about the required content of reports required for mental health cases. Available at: https://www.judiciary.gov.uk/publications/practice-direction-first-tier-tribunal-health-education-and-social-care-chamber-statements-and-reports-in-mental-health-cases/
Normally, one would expect that an increased caseload would result in delays before tribunals. This has not occurred in the context of mental health tribunals. The timeliness of cases has remained relatively static and has shown improvement during the period in which caseloads have increased. In 2013, the average timeliness of cases was as follows: 1 week for section 2 cases; 13 weeks for restricted patients; and 8 weeks for non-restricted patients. In 2017, the average timeliness was: 1 week for section 2 cases; 12 weeks for restricted patients; and 6 weeks for non-restricted patients.

What has changed has been increased judicial sittings to cope with the caseload. As figure 8 below shows, the number of judicial sittings in mental health tribunals increased from 41,500 sittings in 2010/11 to 50,953 sittings in 2015/16. The increase in judicial sittings has been necessary to ensure that cases are heard and decided in a timely way. One consequence of increased judicial sittings is that the Ministry of Justice, as the responsible government department, will have borne the additional costs of such sittings. Accordingly, the Ministry of Justice has an interest in reducing demand into the tribunal system.

Fig. 8

Source: Ministry of Justice, Tribunal Statistics Quarterly June 2017

71 July 2013 Tribunal Statistics Quarterly.
72 July 2017 Tribunal Statistics Quarterly.
3.2. The patient voice

A related challenge concerns the need to ensure that patients can have their voice heard. One of the key values that informs the work of tribunals is the use of fair procedures by which affected people can participate in decision-making. Achieving this in practice in the mental health context poses various difficulties. Nonetheless, despite the practical constraints mental health tribunals sometimes face, a 2011 report by the Care Quality Commission, *Patients’ experiences of the First-tier Tribunal (Mental Health)*,\(^{73}\) suggests that the tribunal process provides patients with a number of helpful opportunities. Importantly, patients can have their voice heard. Such an observation can be interpreted in a number of ways. The positives are that the hearing provides an opportunity for the patient’s case to be reviewed and for them to speak about their experiences. On the other hand, the mental health care system should be able to offer a patient a voice throughout the experience. Patient collaboration is recognised as offering the most therapeutic approach to care in most clinical settings; better patient engagement is achieved through partnership and this requires patients to be fully involved in the process.\(^{74}\) For many patients, discharge from hospital may not be the goal, but a tribunal hearing provides a forum to scrutinise the patient’s progress, consider next steps and evaluate the patient’s continuing needs. Importantly, the tribunal hearing acts as a protective mechanism to safeguard the patient.

3.3. The role of independent mental health advocacy

Following the introduction of Independent Mental Health Advocates (IMHAs) under the Mental Health Act 2007, access to some form of independent legal support and representation has been strong. The Care Quality Commission observed that most detained patients knew that they were entitled to legal support both in terms of providing legal advice and representing them during


tribunal hearings. However, easily accessing support and high quality legal provision may not necessarily be a universal experience by patients, where many rely on hospital referrals for lawyers. There is currently no research on this and it is an area which should be examined more closely. IMHAs, however, offer a valuable bridge between the patient, lawyers and the clinical environment. The lack of information regarding a patient’s detention status, their rights and the tribunal process has previously been recognised as a major concern. The use of independent advocacy may offer an effective response to this by increasing patient self-determination and providing a mechanism to support patients present a more holistic picture of their current state of health, though again, mapping IMHA presence nationally would be a valuable step. The role of an advocate is to act as a conduit for patients to enable them to promote their own voices, express their wishes and to facilitate participation. However, despite the valuable contributions made by IMHAs, practical limitations remain. Difficulties with funding continuity experienced by many different organisations providing independent advocacy services prevent individual advocates from building up rapport with patients over the longer term. The benefits of advocacy require sufficient time and certainty to enable trust and confidence to flourish.

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83 For example, getting the funding model right has so far proved difficult. This was highlighted in Department of Health, Post-legislative assessment of the Mental Health Act 2007: Memorandum to the Health Committee of the House of Commons Cm 8408, London, TSO, July 2012, p 9.
3.4. Mental health tribunal delays

Despite the valuable role of the mental health tribunal, some significant system problems exist which negatively impact on the patient experience. Notably, delays are particularly problematic. Where some detained patients must be seen quickly, for example, section 2 patients, others are forced to wait. Delays in the process contribute to many negative patient experiences, leading to additional distress and anxiety. This is not a new problem, though it has been exacerbated by the rise in detention rates across the various commitment provisions in the Mental Health Act 1983. In 2002, it was found in the case of *R v Mental Health Review Tribunal and Secretary of State for Health, ex parte KB and 6 Others* that delays in mental health tribunal hearings breached patient rights to timely reviews under Article 5 ECHR. In this case, the individuals concerned had all experienced repeated adjournments. The strain on the mental health tribunal system around this time emerged following policy shifts around funding patterns and practice changes. Patients were being placed in smaller units rather than large hospitals and this had had a knock-on effect in terms of the number of tribunals that needed to convene and the frequency in which they met. At the time of this case, shortages in consultant psychiatrists sitting on tribunal panels was noted as a factor that influenced the opportunities to arrange tribunal hearings. Although the practical challenges facing the tribunal system at the time were acknowledged, delays were deemed unjustified and detrimental to the patient. Delays were found to breach article 5(4) of the ECHR. The delays reflected systemic inadequacies and inefficiencies in the administration of the tribunal system. Furthermore, patients were being denied their absolute right to a speedy hearing which the state was obliged to provide. In an effort to reduce delays and counter the effect of rising caseloads, judicial sittings have risen to cope with the increased demand. However, to ensure cases are heard quickly and in a timely fashion, tribunal costs are going up.

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85 *KB & Ors, R (on the applications of) v Mental Health Review Tribunal* [2002] EWHC 639 (Admin).
3.5. Other challenges

Other challenges with the hearing process exist which can impact negatively upon both the patient experience and the efficiency of the tribunal system. For example, the pre-hearing medical examination. Details of the pre-hearing medical examination of the patient is laid down in rule 34 of the Tribunal Procedure Rules. The medical member of the tribunal panel will conduct a pre-hearing examination of the patient in all section 2 cases, unless the patient objects. For other patients, the examination will take place if the tribunal is informed 14 days before and in writing that an examination is wanted or the tribunal has directed that there should be an examination. Medical examinations should normally occur where a patient fails to attend the hearing. For patients that have had a pre-hearing medical examination, the experience has not always been helpful. Raised levels of anxiety and fear are quite common. The Mental Health Act 1983 Code of Practice notes that ‘[h]ospital managers must ensure that the medical examiner can see patients who are in hospital in private, where this is safe and practicable.’ Examinations are sometimes rushed, inconsistently undertaken with different approaches, and often with diverse emphases. Questions are raised regarding the value of the examination, given the recognised limits of the process, and the influence of it on the hearing outcome.

Other issues can create problems within the tribunal system. Hearings are usually held at the hospital where the patient is currently detained. This has the advantage

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86 The Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 (2008 No. 2699 (L. 16) PART 4 CHAPTER 1 Rule 34.
87 See, Amendments to the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 at: http://www.mentalhealthlaw.co.uk/media/Practice_Direction_and_Guidance-Medical_Examinations.pdf
of making it easier for the appellant to appear in person before the tribunal. Hearings are not then like ‘court hearings.’ They are typically held in private unless the tribunal considers that the in the interests of justice the hearing should be in public. Yet, mental health tribunal panels are facing increasing pressure because there is a lack of private space left available in hospitals for hearings. This is problematic as the alternative is for hearings to take place on the ward or in other more public locations. This issue is intensifying with increases in tribunal caseloads. The importance of the built environment upon legal proceedings is signalled as a major issue around how legal processes and proceedings are perceived. Furthermore, difficulties over space within hospitals for hearings also raises the question about the perceived independence of the process when carried out in-situ. It is possible that a perception may arise that the tribunal is not acting as an independent judicial mechanism. Yet, overcoming this may be difficult given the practical challenges surrounding the needs of mental health patients.

The seminar exposed tensions and constraints facing mental health tribunals in daily practice. The discussion hinted at a level of ‘crisis management’ needed to deal with the significant rise in caseload. There was also a real sense from the discussion that all aspects of the ‘system’ from clinicians making detention decisions, through to tribunal panel members were doing the very best they could given the practical limitations they faced. The value of the tribunal process for patients was highlighted, and is partially dependent upon the way in which the hearing is organised and directed by the panel members. The inextricable link between the entry of patients into the mental health system and tribunal caseload was acknowledged. Reducing caseload is not any easy task and relies upon a multi-agency approach to accommodate the complexity of the problem.

Chapter 4

Next Steps for Mental Health Tribunals

The Ministry of Justice’s *Transforming Justice* paper\(^91\) sets out a far-reaching plan for court reform with technology and innovation as its heart. Although mental health tribunals are not currently the focus of this reform programme, the paper notes ‘potential to extend...[these proposals to]...other areas such as Mental Health.’\(^92\) The expectation is that use of technology will improve access to justice, providing tools to help people understand what their rights are and how to protect them. Beside this, robust case management systems are to be put in place with the intention of improving efficiency. Ambitious plans such as these hold the key to significant gains in system management, however, it is recognised elsewhere that challenges are also possible. \(^93\)

Scope for technology in the mental health tribunal system is evident and may have a valuable impact in overcoming some of the practical difficulties experienced by panels and patients on a regular basis. For patients, with the help of legal representatives and/or IMHAs, online support could improve patient experiences. One of the concerns noted by the Care Quality Commission\(^94\) was that patients did not always have the information they needed both in terms of how the detention process worked, what their rights were and how they could initiate the review process. The introduction of IMHAs has made considerable inroads into responding to this concern; access to online support would be valuable and would

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reinforce the position of the patient within the relationship. Use of technology could also greatly assist in the evidence gathering process, the hearing itself and follow-up.

Despite the benefits that may come from greater use of technology, there is a need to be mindful of the particular vulnerability of individuals being formally detained and being seen by mental health tribunals. There is a clear tension between the focus on efficiency and ensuring legal safeguards and protections are maintained. This issue is particularly evident when examining the question of whether cases should be decided after an oral hearing or solely on the papers. Studies examining other tribunals systems have considered the debate. Oral hearings offers the benefit of the tribunal panel meeting the patient. In addition to the medical reports and other paper evidence supplied as part of the hearing process, the tribunal panel have an opportunity to hear direct evidence given by the patient themselves. The informal and inquisitorial nature of the tribunal also enables the panel to ask questions and assist the patient allowing evidence to be drawn out from the patient that might be important. Indeed, mental health tribunal proceedings are often likened to a case review. Hearing a case on the papers loses much of this exchange. A tribunal will only be able to base a decision on the paper evidence submitted and there will be no opportunity to interrogate this evidence further. Within mental health, paper hearings without the patient present do take place. For example, in 2016/17, out of 4,645 applications against CTOs, 520 of those were undertaken on the papers only. Taking account of the withdrawn applications, this figure represents nearly 14% of the hearings undertaken during this period.

Paper hearings do aid timeliness and assist with the goal of driving up efficiency. However, as Thomas observes, oral appeals are more commonly allowed compared to those heard on the papers. ‘Looking at these data, it is apparent that

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97 Tribunal Secretariat, *Outcomes of applications against CTOs to the First-Tier Tribunal (Mental Health)*, 2016/17.
appellants who opt for oral appeals experience higher success rates than those appellants whose appeals are determined on the papers.\textsuperscript{98}

In order to respond to the challenge of increasing mental health tribunal caseloads, it is important to ensure reforms are informed by evidence. More research, consultation and use of pilots are essential. Building on the research undertaken by the Care Quality Commission on patient experience of the tribunal system would also be valuable. Detailed mapping and evaluation of the role and impact of IMHAs to date and the potential expansion of the role as a bridge between the care and legal system would also offer significant insight.

Improving efficiency within the mental health tribunal system is not an easy task. This is largely because the tribunal system cannot be viewed separately. Tribunal caseloads are directly linked to initial decisions to detain under the Mental Health Act 1983. Mental health tribunals review all cases whereas in other tribunal contexts, such as immigration and social security, the appellant must decide whether or not to appeal. While detention rates (under all relevant provisions) are high and getting higher, the impact will be felt by mental health tribunals. Looking forward, it is important to understand better why greater reliance is being placed upon the Mental Health Act, and what, if anything can be done to resolve this. Undertaking empirical research into this is essential.