Dr Tom Webb reflects on the recent independent review of the Mental Health Act 1983 and argues that the proposals relating to the Hospital Managers' s.23 discharge power are problematic.

On 6th December 2018 the Independent Review of the Mental Health Act 1983 published its Final Report. While all involved in drafting this wide-ranging and thought-provoking document undoubtedly had good intentions, the proposals relating to the Hospital Managers' s.23 discharge power (s.23 MHA 1983) are problematic.

The Review has, unfortunately, repeated past mistakes in making a number of proposals regarding s.23 founded on uninformed or, at least under-evidenced, assumptions. The Review proposes the removal of the discharge power, compensated for only by the limited transfer in spirit – not substance – of some s.23-based review responsibilities to an already overpressed Mental Health Tribunal ('the Tribunal'). The consequences of these proposals cannot have been understood by the Review since the Report confesses:

'We do not know how many hearings take place a year or what the discharge rate is, as there is no nationally collected data.'

That the Review would, without any sense of the size and shape of the processes concerned recommend a legislative leap in the dark may seem strange. However, it is in keeping with how s.23 reform has historically been approached (see Webb 2018; and here).

The current context

The Hospital Managers' s.23 discharge power is significant, but 'invisible' (Bartlett & Sandland 2014). It enables discharge from compulsory care against medical advice.

A variety of specific processes take place under s.23 (*Code of Practice*, chapter 38):

1. Patient-initiated challenge to the legality of the section authorising compulsory care.
2. Review of renewal decisions (ss.20, 20A).
3. Review of s.25 barring orders preventing Nearest Relative discharge (a routine AHM function the Review appears to have overlooked (p.84)).
4. AHM-initiated reviews.

When referring to the "Hospital Managers" in this context, reference is generally being made only to *Associate* Hospital Managers (AHMs). AHMs are appointed (not employed) by individual organisations (e.g. an NHS trust, 'the Manager'), which delegates the s.23 power to AHMs. This arrangement allows the organisation to have its employees' decisions independently reviewed where they might otherwise only be subject to internal, administrative-managerial oversight.

The Report says that AHMs are 'local, lay people' (p.145). Section 23 is locally administered, and the Review is correct that 'there is no national job description or framework' for AHMs. However, there is little evidence about the professional or lived experience of those sitting as AHMs, so to conclude that they are 'lay' is not possible.

Lastly, the Review *may* be correct that 'the patient does not usually have a lawyer to represent them', or that they may only have 'a trainee solicitor … using [the hearing] as "practice for the real thing" [implicitly, the Tribunal]' (p.145). However, there is no national evidence to support these claims. If the Report is correct, a lack of representation at the hearings is likely due to the legal aid

rules, which privilege Tribunal hearings and discourage representation elsewhere (legal aid rules, 9.71-9.75).

The proposals

The Review makes four proposals in relation to AHMs:

1. Remove their power of discharge (p.145).
2. Discontinue AHM-led renewal review, and convert this to administrative-managerial review, perhaps supplemented by a second clinical opinion (p.146).
3. Compensate for the above loss of review via very limited reallocation of oversight to the Tribunal, though not by any substantive transfer of responsibilities (pp. 25, 146).
4. Convert the AHMs from an empowered reviewing body to Hospital Visitors who would '[visit] wards and [make] reports' only (p.146).

The removal of the discharge power is risky given the absence of national statistics that would indicate the effect of these. At present, the scale of the process has to be inferred from the government's *guess* in 2004 that there may have been 10,000 hearings in the preceding year (Joint Committee Report, paras 301, 307).

The evidence on discharge rates is almost equally poor, with limited statistical information suggesting a rate of 2-8.4% (see Webb 2018). Yet, when considered alongside figures from a small study indicating that in 27% of cases merely asking for a hearing prompted a discharge by the Responsible Clinician (RC) (MHAC Report, 2005-2007), the effect of the s.23 power looks altogether more significant. Thus, the suggestion that 'managers are likely to agree with the [RC]' (p.145) is not necessarily problematic, given that the RC should have already discharged strong cases, leaving only either-way, and weaker applications to AHMs.

In the light of these figures, the second and third proposals take on a different character. When, if the process becomes purely managerial-administrative instead of quasi-judicial, will the patients discharged by AHMs be discharged? When will the patients discharged after asking for a hearing, be discharged? Where will the 10,000+ hearings currently heard by AHMs go? There is no suggestion that they should be heard by the Tribunal (p.146). The proposals appear to run counter to the aim of 'reducing compulsion' in the Report's title.

The last proposal argues for the removal of the AHMs' teeth, their power of discharge, and their conversion to a mere report-generating process. Under the proposals, the AHMs will be encouraged to raise concerns about inadequate care and inappropriate treatment but will lack powers to enforce their conclusions. Toothless processes are rarely a force for change. They might, ironically, even become a weak duplication of the Care Quality Commission or Non-Executive Directors.

On its face, the Review proposes a reduction in the available safeguards for patients, and for healthcare organisations to have their decisions independently examined. Furthermore, any economic savings in staff time may be wiped out by patients staying in hospital longer, or filing costly legal challenges (e.g. judicial reviews) against administrative-managerial decisions not overseen by the Tribunal (i.e. renewals). Far from '[duplicating] the role of the Tribunal' and 'not [representing] an effective use of scare resources' (p.145), the AHMs may save effort and cost.

Correcting the Evidence Deficit

The Review's proposals can be critiqued because they do not have firm evidential foundations. I am

currently undertaking research, funded by Lancaster University, which aims to fill the evidential gap identified above, and provide a national picture of the various local practices and policies relating to s.23. Consequently, I hope that it will soon be possible to have a more informed discussion about the future of AHMs as part of the conversation started by the Review.

Declaration of interest: Dr Tom Webb is an AHM for Lancashire Care NHS Foundation Trust.