Mental Health Tribunal for Scotland

President: Laura J Dunlop KC

Response of the Mental Health Tribunal for Scotland to the Study of Experiences of hearing attendees published in September 2022

1. We have read with interest the report of the Edinburgh Napier University and Queen's University Belfast Study of the Mental Health Tribunal for Scotland (MHTS). Its findings were discussed in workshops at the training days for members in the Autumn of 2022. The written response below draws on those workshops, and has been compiled with the assistance of a small group of members. Responsibility for the final text remains with the office of the President.

2. The report records experiences of a range of people who have had involvement with MHTS (including patients, named persons, health and social care professionals, independent advocacy workers, solicitors and MHTS panel members), and considers the Tribunal's preparedness for potential future changes. Although the study found it difficult to recruit the hoped-for numbers of patients and named persons (difficulties which we also experienced in our own research on the views of patients about telephone hearings), an independent research study offers undoubted benefit to the Tribunal in its reflections on the impact of processes and practices on those at the centre of its proceedings.

3. In this response, for reasons of consistency, we adopt the language of the legislation, but we recognise that terms such as 'mental disorder', 'mental illness' and 'patient' carry unwelcome connotations for many people they affect. Some of these terms, and their use in legislation, may change in the next few years. We also use the generic term 'applications' to describe cases before the Tribunal, although 'reviews', 'references' and 'appeals' also arise for decision.

4. We begin with some general points. MHTS is a creature of statute. That means that its role is both defined and confined by the Act of Parliament that created it, namely the Mental Health (Care and Treatment) (Scotland) Act 2003. The primary function of the Tribunal is to consider and determine applications made to it. These are applications in relation to the compulsory care and treatment of people with mental disorder. Whether or not someone has a mental disorder, as defined in the Act, is itself a matter which the Tribunal must address. If the Tribunal finds that mental disorder exists, compulsory care and treatment may be authorised, provided other criteria are also satisfied. Likewise, applications made by patients or named persons (occasionally others, such as listed initiators) for revocation of orders may be granted if the criteria for compulsory care and treatment are not currently met. Generally speaking, the onus of establishing the existence of the criteria falls on the State and not on the patient or named person. The person bearing the onus is therefore usually the mental health officer or responsible medical officer making the application. This is

likely to influence the amount of evidence which is presented by or on behalf of that person. Other incidental applications will be determined on the specific criteria articulated in the legislation – for example, appeals against hospital transfer, applications for removal of a named person or challenges of the level of security to which someone is subject.

5. The role of the principles set out in section 1 of the Act in the exercise of determining applications will vary, both with the particular principle concerned and with the nature of the application. Some of the principles are directed to the hearing process, some are relevant to outcomes and some are both. Whether an application is granted or refused is likely to turn on the satisfaction or not of the terms of the specific section in the Act which governs that application. The Act is accompanied by rules of procedure (some of which are general, primarily the Practice and Procedure Rules 2005, and some of which are particular, such as those relating to conflict of interest or cross border transfer). These pieces of primary and secondary legislation together provide a comprehensive code for the exercise of the powers of the Tribunal, and the powers and duties of those authorised to provide care and treatment without the consent of the person to whom it is given. Proper application of these domestic rules is itself a matter of human rights law; any deprivation of liberty must comply with domestic rules which, in turn, have to be in accordance with the European Convention on Human Rights.

6. Aspects of the Report of the Study and its recommendations may necessitate clarification of what the Tribunal, as a judicial body, can and cannot do. The delivery of care and treatment is not primarily a matter for MHTS, with duties being placed on responsible medical officers and mental health officers (and their parent bodies). The giving of medical treatment is dealt with by part 16 of the Act. The Tribunal's power to issue Directions, referred to in the report at paragraph 3.2.6(a), is a procedural power to be exercised in the context of determining cases, for example by directing the production of documents or the attendance of a witness, and not to operate after cases have been determined. The purpose of Directions is so that Tribunal proceedings are handled as fairly, expeditiously and efficiently as possible, rather than, as suggested by some participants in the Study, a power to issue Directions in relation to care and treatment.

7. The delivery of advocacy to participants in hearings is, likewise, not a matter within the remit of the Tribunal. The provision of advocacy for people in relation to whom applications are made to the Tribunal is the duty of local authorities and health boards (section 259). There is at present no statutory duty on any organisation to provide advocacy for named persons, though in practice advocates do support named persons at hearings from time to time. Ensuring that named persons have the opportunity to access independent advocacy and legal representation before, during and after a tribunal hearing is not, therefore, within the remit of the Tribunal (cf recommendation 4). Members recognise the benefit of such support, however, and are likely to enquire about its availability and to be receptive to motions to adjourn where it is being sought.

8. In relation to the reference in recommendation 1 to the need to consider alternatives to non-consensual care and treatment, we would observe that it is the position of many professionals that resort is not made to an application for compulsory measures where treatment can be achieved on a consensual basis.

We would also observe that the criteria for the making of an order include that it is ‘necessary’, thus requiring the Tribunal to address in every case whether compulsion can be avoided. As recognised in the report, resources actually available are likely to be relevant.

9. Our comments on the remaining recommendations follow.

10. Recommendations 1 and 9 highlight the need in every hearing to prioritise respect for diversity, and principles of equality of treatment. These are matters to which the Tribunal as a body pays constant attention. It is important to record that, in 2021, the annual training for members included a workshop on unconscious bias, as did the induction training for new members in 2022. The need periodically to repeat such training is understood.

11. Particular adverse experiences at MHTS hearings are referenced in the report, with some being necessarily subjective. This is not to deny the reality of the experience for the person concerned but, in the absence of any context, other relevant factors are excluded from consideration. Some experiences narrated appear incapable of justification, for example the use by a convener of a phone during a hearing (page 41). A complaints process does exist, and is publicised on the MHTS website. Aside from formal process, concerns about incidents can always be drawn to the attention of the President’s Office: they will always be investigated.

12. The remaining recommendations addressed to the Tribunal in large part refer to matters which are reflected in the section 1 principles and should form part of the procedural expertise of members, and be reinforced by training. These are

- The need to recognise and, as far as possible, compensate for, imbalances of power;
- The need to identify and mitigate obstacles to patient participation;
- The requirement to obtain the views of named persons and to present those, and the views of patients, fully and accurately in the Full Findings and Reasons document;
- The requirement for the provision of information about the hearing, the Order sought and the potential outcomes of proceedings;
- The need for scrutiny of care plans and services provided, to promote reciprocity.

A well-conducted hearing would achieve all these goals.

13. There are occasions when some are not achieved. This can be for a variety of reasons. Unwitting errors and oversights do occur. Below, we list steps which the Tribunal has taken in recent years to minimise the number of such occurrences, with the addition of ways in which we can enhance these reforms to reflect points made in the Study report:

- Since 2020, we have implemented more uniform setting out of Full Findings and Reasons, with headings to reflect, for example, the need to set out near the start the patient’s position on the application. The position of the named person is not always made explicit in the hearing process; there can be issues about maintaining relationships (similarly to the point made in

paragraph 3.2.3 about preserving the relationship between doctor and patient). **We will consider the best way to make provision for recording the views of the named person in the Full Findings and Reasons document.**

- The filming of a mock tribunal, highlighting specific areas where there can be omissions to provide explanations or to allow participation of a relevant person, with use of the film at members' annual training in 2020 and 2021.
- **We will address the need to make express reference at hearings to the content of care plans**.
- The provision of written information on our website concerning rights to request documents and/or become a party under the Tribunal's rules.
- Utilisation of the full quota allowed for MHTS members at every training course on Tribunal craft run by the Judicial Institute for Scotland.
- Biannual forums for service users, carers and advocacy workers, which now take place online. This lockdown-related change has led to greater attendance and participation, in both the numerical and the geographical senses.

14. Work in progress at present includes the development of a new website, with greater information for service users and their named persons on what hearings may involve; efforts to improve hearings with interpreters, both foreign language and BSL; and a programme of resumption of in-person hearings (or, in some locations, video hearings) to improve the communications between participants in tribunals. This last project has included the introduction of a mechanism for a patient to request a particular hearing format, subject to practicalities.

15. Work which we intend to take forward will include further reflection on how to ensure a degree of standard practice in the conduct of hearings, especially in opening and closing. We will also try to focus more clearly on the place of the principles, always bearing in mind the duty to reach a decision on the specific statutory criteria for grant or refusal of the particular application before the Tribunal (see paragraph 4 above). These topics will feature at training over the next year.

16. As we look to the future, it is also relevant to address a concern expressed in the Report, to the effect that the imminent transfer of the Tribunal into the First-tier Tribunal for Scotland could result in a 'dilution' of the specialist role of the Tribunal (page 11). We understand this to relate to an option mooted when the transfer was first proposed some years ago, but the draft secondary legislation makes clear that the composition of each tribunal after transfer will remain as at present, with a legal member as convener, and a psychiatrist and a person with experience of mental health services as the other two members (Draft First-tier Tribunal for Scotland Mental Health Chamber and Upper Tribunal for Scotland (Composition) Regulations).

17. In conclusion, we note and agree with the recognition 'that patients who are subject to MHTS processes are there because they are either deemed unable or are unwilling to consent to care and treatment for mental disorder and that such processes and their outcomes are likely to be distressing and unwanted' (page 66). The areas of someone's life in which intervention takes place are intensely personal, and fundamental rights are in issue. It is a sign of the inherent complexity of the jurisdiction that the study report often features opposing opinions

on the same point. But none of this detracts from our recognition that the Tribunal must constantly strive to improve its practice, to reflect new ideas and approaches and to protect the rights of individuals to the greatest possible extent in the cases it is asked to determine.

MHTS President's Office
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