Overview of the Mental Health Tribunal for Scotland – Dr J J Morrow, President of the Tribunal

Introduction

The commencement of the operation of the Mental Health Tribunal for Scotland (“the Tribunal”) in October 2005 dramatically altered the Scottish approach to, and application of, mental health law. With the Tribunal having completed its fifth year of operation, it is timely to analyse developments in, and the current ethos of, mental health law in Scotland.

To begin with, this article places Scottish mental health law in its historical context. In this way it is possible to chart the changing attitudes towards mental health issues from the days of the Lunacy Acts in the 19th century, to the current Mental Health (Care and Treatment) (Scotland) Act 2003(1) (the “2003 Act”). This historical perspective provides the background to an exploration of the provisions of the 2003 Act and, specifically, the establishment of the Mental Health Tribunal for Scotland.

It is argued that the nature of the 2003 Act and the operation of the Mental Health Tribunal for Scotland over the last five years is the dawn of a therapeutic approach to the application of mental health law in Scotland. That is to say, there have been, and continue to be, increasing attempts to improve the therapeutic functioning of Scottish mental health law for the benefit of patients.

Background to the 2003 Act

The present system of mental health law in Scotland is the product of evolving perceptions of mental health and the role of the legal system in addressing issues of mental ill health. Prior to the enactment of the 2003 Act, the principal source of mental health law in Scotland was the Mental Health (Scotland) Act 1984 (“the 1984 Act”) (2). Between 1984 and 2003, the 1984 Act had been subject to numerous amendments undertaken in a piecemeal legislative fashion (3). The 1984 Act, as enacted, did not itself introduce any new law, rather it consolidated existing legislation and re-enacted the Mental Health (Scotland) Act 1960 (4) (“the 1960 Act”) and its amendments (5).

In order to find the last major reform of mental health law in Scotland before the 2003 Act it is necessary to look back half a century. Between 1954 and 1957 the UK wide Percy Royal Commission, followed in Scotland by the Dunlop Committee, gave detailed consideration to mental health legislation (6), resulting in the 1960 Act. The 1960 Act was a “…liberalising measure” (7) which “sought to ensure that people with mental disorders were not automatically subject to legal controls, and to protect the rights of those who were detained against their will.” (8)

A change in attitude towards mental health law is apparent simply from the titles of the various pieces of Scottish legislation. In the titles of the various pieces of legislation the term “lunacy” was replaced by “mental deficiency” and that in turn was replaced by reference to “mental health”. As is discussed below, the title of the 2003 Act emphasises the central philosophy of the legislation, which is the care and treatment of persons subject to compulsory measures within the mental health system (9).

In 1998 – before devolution was introduced to Scotland – the Scottish Office invited the Right Honourable Bruce Millan to chair a Committee to review mental health law in Scotland and to make recommendations for its reform (10). The terms of reference of the Committee were:

“In the light of developments in the treatment and care of persons with mental disorder, to review the Mental Health (Scotland) Act 1984, taking account of issues relating to the rights of patients, their families and carers, and the public interest; and having particular regard to:

[Further details are not provided in the image]
....
mentally disordered patients from the existing civil courts and transferred it to the Mental Health Tribunal for Scotland, a new judicial body(27), the decisions of which are appealable to the superior courts(28). Third it removed from the Scottish Ministers the power to make decisions in relation to the continuing detention of mentally disordered offenders subject to a compulsion order and a restriction order imposed by the criminal courts. Previously it had been for the Scottish Ministers (and before them the Secretary of State for Scotland) to make the final decision on whether such patients should be released from hospital. The appropriateness of politicians being involved in decisions involving continuing detention of patients had begun to be questioned over the years and many were of the view that such decisions should be taken by an independent body. The 2003 Act removed jurisdiction over such patients from the Scottish Ministers and brought those patients within the jurisdiction of the Tribunal.

Finally, and unusually for Scottish legislation, the 2003 Act set out a series of principles which apply to those who take decisions in respect of mentally disordered patients – including the Tribunal – and which must be taken into account by them in discharging their functions(29). These principles largely reflect principles recommended by the Millan Committee(30). They include inter alia, the present and past wishes and feelings of the patient relevant to the discharge of the function(31), the importance of the patient participating as fully as possible in the discharge of the function(32) and the importance of providing maximum benefit to the patient(33). After having regard to each of these matters, the person discharging the function under the 2003 Act must discharge the function in the manner that appears to the person to involve the minimum restriction on the freedom of the patient that is necessary in the circumstances(34).

It is clear from the principles set out in the 2003 Act that the focus of decision making is squarely on the patient, on the patient’s needs and wishes and on the least restrictive option available. This is a therapeutic approach which requires the Tribunal to apply the law in a manner which will promote the mental well-being of the patient(35). In addition, there are other therapeutic mechanisms which ensure that the patient is placed at the heart of the decision making process. For example, advance statements allow patients to set out their own preferences as to treatment which they should receive in the event that, due to mental disorder, they become incapable of expressing their views at the relevant time(36); patients have access to advocacy workers(37) to assist them in expressing themselves and setting out clearly their own views – both to medical professionals and in Tribunal hearings; and patients are entitled to be legally represented at all Tribunal hearings. All of these mechanisms are designed to ensure that the patient’s voice is heard clearly by all those who make decisions about the patient’s care and treatment including, and indeed particularly, the Tribunal.

The Mental Health Tribunal for Scotland

Arguably the greatest change made by the 2003 Act was the establishment of the Mental Health Tribunal for Scotland(38). The 2003 Act places the Tribunal at the centre of mental health law in Scotland as the forum for granting, approving and reviewing compulsory measures for the detention, care and treatment of people in Scotland who have a mental disorder(39). The Tribunal comprises a President(40) and some 350 members(41). Those members fall into 3 categories: legal members, being legally qualified persons of at least seven years standing; medical members, being psychiatrists or medical practitioners with psychiatric experience; and general members, being persons who have experience of mental disorder and using mental health services, carers of such persons and professionals with experience of working with people with mental disorder such as nurses, psychologists and social workers(42). Each tribunal panel comprises three members, one from each category. These three-member tribunal panels hear cases – approximately 4,200 hearings a year – at venues(43) throughout Scotland. The Tribunal also has a shrieval panel(44) as proceedings before the Tribunal(45) in respect of patients subject to a compulsion order and restriction order, a hospital direction or a transfer for treatment direction must be convened by either the President or a sheriff (a Scottish judge)(46).

The Tribunal considers cases where a patient is, or is to be, detained or made subject to compulsory treatment measures. In short, the Tribunal becomes involved at the point where patients enter the mental health system involuntarily. This can happen by two distinct routes. The first and most common route is where a person living in the community becomes so mentally unwell that an intervention by psychiatric services is required against the wishes of the patient(47). The second route is where a person enters the mental health system through the criminal justice system(48).

The 2003 Act provides mental health professionals with the legal mechanisms allowing for the liberty of a person living in the community, or voluntarily in hospital, to be restricted where that person becomes so mentally unwell that intervention by psychiatric services against the wishes of the patient is required. The three types of intervention provided for in the 2003 Act are detention of a person in hospital on an emergency basis for up to 72 hours (by a certificate granted by a medical practitioner)(49), detention in hospital and the administration of medical treatment on a short-term basis for up to 28 days (by a certificate granted by an approved medical practitioner, the certificate being subject to revocation by the Tribunal on application by the patient or another person known as the patient’s “named person”(50)),(51) and the compulsory provision of treatment to a person whether in hospital or in the community for up to 6 months, and renewable thereafter, under a compulsory treatment order(52) (a compulsory treatment order being an order granted by the Tribunal and which can thereafter be extended on application of the responsible medical officer(53) by order of the Tribunal(54) or by determination of the patient’s responsible medical officer(55), which determination may be subject to review by the Tribunal, either automatically(56) or by application by the patient or by the patient’s named person(57)).

The 2003 Act also makes provision for circumstances in which a person enters the mental health system through the criminal justice system. This can occur either where a person serving a sentence in prison becomes mentally unwell and requires to be transferred to a psychiatric hospital, or where a court disposes of a criminal case by making an order requiring the accused person to be detained in a psychiatric hospital, for either a limited or an unlimited period of time.

The 2003 Act subjects all of these legal mechanisms by which a patient’s liberty is restricted to strict oversight and control, placing on mental health professionals obligations of notification of emergency and short-term detentions and giving powers to the Mental Welfare Commission for Scotland to intervene in certain circumstances(58). However, most importantly, the 2003 Act places the Tribunal at the centre of the process of making decisions which restrict the liberty of mentally disordered patients.

Finally, where a patient is detained in a high security psychiatric hospital in Scotland – the State Hospital at Carstairs – whether having entered
that hospital direct from the community or by order of a criminal court or on transfer from prison, the 2003 Act provides a mechanism by which such an individual may apply to the Tribunal to hold a hearing before a three-member tribunal panel to consider whether that person requires the conditions of special security which can be provided only in a state hospital, or whether that person should be transferred to a psychiatric hospital with lower security (59).

In short, the 2003 Act provides a whole series of mechanisms giving the Tribunal oversight of the detention and compulsory treatment of mentally disordered patients in Scotland: from the power to revoke a short-term detention certificate granted by an approved medical practitioner; the sole power to grant a compulsory treatment order; the power to extend or vary (by changing it from hospital to community based, and vice versa) a compulsory treatment order; the power to revoke a compulsory treatment order or a responsible medical officer’s decision to extend it; the power to review and revoke those orders by which patients who have entered the mental health system through the criminal justice system are detained in hospital and subject to compulsory treatment; and the power to determine whether a patient being detained in the State Hospital at Carstairs is being detained in conditions of excessive security.

No matter how a patient’s case comes before the Tribunal, whether on application by the mental health officer, by the responsible medical officer, by the patient or the patient’s named person, or automatically by operation of the 2003 Act the patient’s case will be considered and decided by an independent three-member tribunal panel. It is that tribunal panel alone which will decide – having heard all the evidence presented to it, whether by the detaining authorities or by the patient – whether the patient should be detained or should be subject to any other restrictions on his/her liberty.

The Tribunal’s Therapeutic Approach

The use of a specialist tribunal marks a dramatic shift from the previous arrangements in Scotland. Under the 1984 Act, it was the sheriff courts – the Scottish courts in which the vast bulk of litigation in Scotland takes place, from serious criminal cases to divorce to contractual disputes – that had jurisdiction to decide applications and challenges in respect of the detention of mentally disordered patients (60).

The system of sheriff courts is inevitably formal. Courtrooms facilitate adversarial proceedings, with the sheriff sitting alone on the bench, formally dressed in a black robe and usually wearing a horsehair wig. Since the sheriff courts handle a whole range of civil and criminal cases, the waiting rooms and public spaces of the court buildings are filled with a broad cross section of society from people accused of petty and serious crimes to parties pursuing divorce actions and child contact disputes. Even when the courts prioritised mental health cases and endeavoured to deal with them sensitively, many aspects of the court process were inevitably organised to suit the convenience of the court due to the sheer pressure of court business. Inevitably in mental health cases it was the court – not the patient – that was the centre of the process. A study by the Scottish Executive found that between April 1998 and March 1999 patients attended court in only 27% of cases and gave evidence in 18% of cases (61). Several reasons were given for the non-attendance of patients at court, including inability to understand the process, lack of confidence and the intimidating nature of the court (62). The court process was thus to some extent anti-therapeutic for patients. Between 1 April 2009 and 31 March 2010 patients attended more than 57% of hearings before the Tribunal.

Unlike the previous system, the 2003 Act and the Tribunal place the patient at the heart of the Tribunal’s decision-making process (63). Tribunals convene in dedicated tribunal suites in community and hospital settings throughout Scotland with which the patient is likely to be familiar (64). Therefore, instead of the patient coming to the Tribunal, “where practical” the Tribunal strives to hold hearings “where it is most convenient for the patient” (65). A tribunal suite comprises a large room with a conference table in which the three-member tribunal panel will hear evidence, as well as waiting rooms for the patient, legal representatives and mental health professionals. In contrast to sheriffs sitting in court, Tribunal members do not wear robes or other regalia, but simply everyday clothes and tribunal members and those appearing before the tribunal generally sit round a large conference table. Usually, the three tribunal members will sit on one side of the table, and those appearing before the tribunal – the patient, any advocacy worker or lawyer, psychiatrist, social worker, nursing staff, expert medical witness – will sit on the other side of the table. The conduct of tribunal proceedings is a matter for the tribunal panel (66), however tribunals generally aim to conduct hearings in an informal manner as possible (67). There is no witness box and people remain seated when giving evidence or making submissions. Patients are informed in advance that if at any stage they want a break in the proceedings they simply need to ask – which they are welcome to do either directly or through their advocacy worker or lawyer – and the tribunal will have a break in proceedings. Simply by operating in a more patient-friendly and patient-focused way the Mental Health Tribunal for Scotland increases the therapeutic nature of mental health law in Scotland as can be seen from the fact that a majority of the hearings before the Tribunal are attended by the patient whose case is being considered.

Another contrast between the old system and the new is that hearings before the Tribunal are held in private and are not open to the public. Again, this may be seen as an example of therapeutic practice as mental health cases are often likely to raise deeply personal issues which a patient may be unwilling to have aired in public (68). Notwithstanding the private nature of the proceedings, tribunal panels are required to provide full written findings and reasons in each case and these written decisions are made available to all parties who appear before the Tribunal. What is more, the Tribunal’s decisions are subject to appeal to the superior courts, either a sheriff principal (a senior Scottish judge) or to the Court of Session in Edinburgh (the highest civil court sitting in Scotland) (69).

An unusual aspect of the appeal process is that the Tribunal itself, being the judicial body which has made the decision being appealed against, has the statutory right to enter appearance in those appeals and defend its decisions (70). The Tribunal has taken a pragmatic and responsible approach to this entitlement. In those cases where the Tribunal, as an institution, has reached the conclusion that an individual tribunal panel has come to a decision which is wrong in law or has been vitiated by a technical procedural impropriety, then the Tribunal has had no hesitation in conceding the appeal. Such a situation has arisen for example, where a tribunal panel has made an order without allowing an adjournment of the case in circumstances where the patient has not had sufficient notice of the hearing and time to instruct legal representation. However, whether the Tribunal is successful in defending an appeal is not the issue. The issue, from the Tribunal’s perspective, has been that the superior courts have had the opportunity to scrutinise decisions made by individual tribunal panels and point out where their reasoning and approach has been in order and, on those occasions where the superior courts have found that the decisions of individual tribunal panels have not been in order, to identify where they have been in error and to clarify the interpretation of what all who are involved in mental health law in Scotland agree are important and complex provisions of the 2003 Act.
However much of an improvement the Tribunal has been on the sheriff court system, there remain a number of areas of improvement for the Tribunal. One example is the significant logistical burden of scheduling three-member tribunal panels to hear approximately 350 cases per month throughout Scotland(71). Recent attempts to lessen this burden have included the extended use of “double hearings”, that is scheduling cases so that a single three-member tribunal panel is able to hear two separate cases in one day(72).

Recent Assessments

Just as the 2003 Act marked an important step forward from previous mental health legislation in Scotland, the Scottish Government has recognised that Scottish mental health law must remain receptive to the needs of patients and evolve accordingly. With this in mind, the Scottish Government established the McManus Committee in 2008 to conduct a limited review of the 2003 Act. The primary objective of the Committee was to consider the operation of the 2003 Act in the context of the principles recommended by the Millan Committee and provide recommendations for the improvement of the efficiency of the operation of the 2003 Act and of patients’ experiences(73). The review was a “limited review” because it did not consider those provisions of the 2003 Act concerning patients subject to a compulsion order and restriction order, a hospital direction or a transfer for treatment direction.

The McManus Committee’s Report recognised that the current tribunal system is “generally working well”(74), but made a number of recommendations for improvement, some of which have clear therapeutic objectives(75). For example, one recommendation is for an increase in the use of advance statements to encourage and maximise patients’ participation in their own care and treatment(76), as well as a recommendation that the Scottish Government ensure that all patients have access to advocacy services taking into account their specific needs, regardless of where in Scotland they are(77).

In 2009, the Scottish Government also reported on an analysis of the early operation of the Mental Health Tribunal for Scotland(78). This report found that the new Tribunal system was “praised for being fairer, more open, and accountable and “patient focused” than the old sheriff court system”(79). It also found the Tribunal system to be more participatory, patients feeling that they were listened to and had a voice(80). The report did, however, raise a number of issues. First, that patients and families can be upset to hear their personal case histories being told to “strangers”(81). Second, that the new system can have a damaging impact on the therapeutic relationship between a patient and his/her psychiatrist or mental health officer, especially where the latter gives evidence in support of a compulsory treatment order which the patient opposes(82). Finally, there was criticism of some Tribunal venues which were considered inappropriate for hearings, for example due to insufficient or non-existent private spaces for patients to speak with their solicitors(83).

Conclusion

The Mental Health Tribunal for Scotland is at the forefront of developing mental health law in Scotland. As the forum for granting, approving and reviewing compulsory measures for the detention, care and treatment of people with mental disorder it has an immense impact upon the lives of those people in Scotland and of their families and friends. The legal framework which established the Tribunal and its subsequent operation demonstrates a new, therapeutic approach to the practice of mental health law in Scotland. In the course of the last five years, the Tribunal has established itself as a specialist mental health tribunal, providing swift access to a judicial process to decide applications and to test, review and decide upon decisions made by medical professionals which impinge upon the liberty of patients with mental disorder in Scotland. Independent, robust and specialist, the Tribunal discharges its judicial responsibilities with the patient at the centre of the process, balancing the rights of patients against the requirements for their own care and treatment and the wider public interest in Scotland.

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Mental Health Tribunal for Scotland

Notes

(1)  http://www.ardendavies.com
(3)  Ibid., paras 11-19.
(4)  c. 61.
(5)  Ibid., para. 5.
(6)  Ibid., para. 7.
(7)  Ibid., para. 7.
(8)  Ibid., para. 7.
(9)  See “The 2003 Act” section below.
(14) The Scottish Executive was rebranded the Scottish Government in 2007. The terms are used interchangeably throughout this article.


(20) The 2003 Act as originally passed by the Scottish Parliament can be found at http://www.opsi.gov.uk/legislation/scotland/acts2003.asp.20030013.en.1 However, note that the 2003 Act should be read in light of subsequent amending legislation. This legislation includes the Mental Health (Care and Treatment) (Scotland) Act 2003 Modification Order 2004 (SSI 2004/533) and the Mental Health (Care and Treatment) (Scotland) Act 2003 (Modification of Enactments) Order 2005 (SSI 2005/465). For a full list of amending legislation see http://www.scotland.gov.uk/Topics/Health/mental-health/mentalhealth/mhlaw/2003actamendments


(22) Ibid.

(23) See the Bill as introduced, available at http://www.scottish.parliament.uk/business/bills/billsPassed/b64s1.pdf.


(29) Section 1 of the 2003 Act.


(31) Section 1(3)(a) of the 2003 Act.

(32) Section 113(c) of the 2003 Act.

(33) Section 113(l) of the 2003 Act.

(34) Section 1(4) of the 2003 Act.


(36) Sections 275 and 276 of the 2003 Act.

(37) Section 259 of the 2003 Act.

(38) Part 3 and Schedule 2 of the 2003 Act.


(40) Schedule 2, para. 3 of the 2003 Act and the Mental Health Tribunal for Scotland (Appointment of President) Regulations 2004 (SSI 2004/155).

(41) Schedule 2, para. 1 of the 2003 Act.

(42) Schedule 2, para 1(1)(a), (b) and (c) of the 2003 Act; the Mental Health Tribunal for Scotland (Appointment of Legal Members) Regulations 2004 (SSI 2004/286); the Mental Health Tribunal for Scotland (Appointment of Medical Members) Regulations 2004 (SSI 2004/374); and the Mental Health Tribunal for Scotland (Appointment of General Members) Regulations 2004 (SSI 2004/375).


(44) Schedule 2, para. 2 of the 2003 Act.

(45) The exceptions being proceedings for the appointment of, or declarator that a specified person is not, a named person in respect of a patient: schedule 2, para. 7(4) of the 2003 Act.

(46) Schedule 2, para. 7(4).

(47) See Parts 5, 6, 7 of the 2003 Act.

(48) See sections 57A (inserted by section 133 of the 2003 Act) and 59A of the Criminal Procedure (Scotland) Act 1995 (c. 46) and section 136 and Parts 9, 10 and 11 of the 2003 Act. For a description of the various stages of the criminal justice process in Scotland see Thomson, Chapter 5 “Psychiatric systems and services for mentally disordered offenders” in McManus and Thomson, Mental Health and Scots Law in Practice, 2005, W. Green and Son Ltd, Edinburgh.

(49) Section 36 of the 2003 Act.

(50) See Part 17, chapter 1 of the 2003 Act.

(51) Section 44 of the 2003 Act.

(52) Section 64 of the 2003 Act.

(53) Section 92 of the 2003 Act.

(54) Section 103(1) of the 2003 Act.

(55) Section 86 of the 2003 Act.

(56) Section 101 of the 2003 Act.

(57) Section 99 of the 2003 Act.

(58) See, for example, the Mental Welfare Commission for Scotland’s right of investigation under sections 11 and 12 of the 2003 Act.

(59) Sections 264(2) and (6) of the 2003 Act.

(60) For an overview of the areas of the Scottish legal system of interest to mental health professionals see: McManus, “Chapter 2: The Scottish Legal System”, in McManus and Thomson, Mental Health and Scots Law in Practice, 2005, W Green and Son Ltd, Edinburgh.

(62) Ibid.


(66) Rule 63(2) of the Mental Health Tribunal for Scotland (Practice and Procedure) (No. 2) Rules 2005 (Scottish SI 2005/519).

(67) Patrick and Smith, *Adult Protection and the Law in Scotland*, 2009, Bloomsbury Professional Limited, Haywards Heath, West Sussex, para. 13.14, which states “The proceedings are less formal than a court setting, but still relatively formal, in view of the importance of the matters under discussion”.


(70) Section 324(3) of the 2003 Act.


(72) Ibid. pp. 4 and 15. According to the report this has “increased efficiency and effectiveness”.


(74) Ibid., p. 67.


(77) Ibid., pp. 10-11.


(80) Ibid., p. 64.

(81) Ibid.

(82) Ibid.

(83) Ibid.