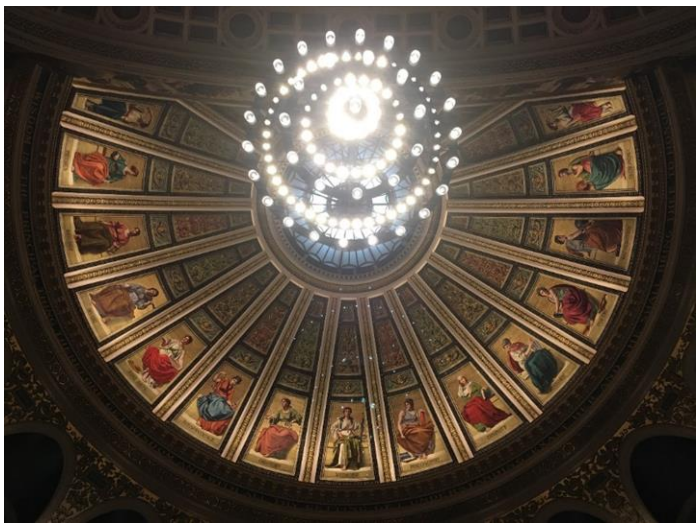
Mental Health Tribunal for Scotland

# Members' Newsletter

# January 2020

**INSIDE**

# Contents



# Message from Laura J Dunlop QC

Dear Members,

This is the first time I have prepared a message for the MHTS newsletter. Recent months have also seen the first time in its history that the Tribunal has lost a serving staff member. Calum Grierson, who died early in December 2019, was a much loved and valued clerk. We were all devastated by his loss, especially at a point where the news seemed a little better, and so sorry for his wife and sons. A tribute to Calum appears on page 5 of this newsletter.

The newsletter features articles and items of interest and relevance for members of MHTS. I would like to thank Jane Patrick for putting it together, and all those who have written pieces for inclusion. If you are reading this as a booklet between hearings, we are pleased to have you – that was part of the plan for moving away from posting out hard copies.

January is nearly over, but it's not too late to send best wishes for the Newish Year, or to mention some of what lies ahead for MHTS in 2020. It is also right to record that arrangements for the Festive Season 2019 worked well, and I am grateful to all staff and members who contributed to that.

We do not yet have a date for **transfer into the First-tier Tribunal for Scotland**, but I can intimate that it will not be before 1 September 2020. We have made suggestions on the draft rules, and we will continue to try to clarify the position about timing.

Following our successful all-member conference in November 2019, **training this year** will revert to the more usual format of several individual days, at different locations. It is likely that there will be a mock tribunal, and this will require an element of role-play. Some people mentioned this in their feedback forms in November, and I think it is worth trying as an alternative way to illustrate points about tribunal craft. Volunteers to play a part will be welcomed. Another constituent of training in 2020 will be the provision of greater support in **how to write FFRs**; although this is primarily a matter for legal members, we will try to include an outline for medical and general members of the principles of well-written decisions. That it is necessary to keep refreshing our skills in this area is demonstrated by the words of Lord Tyre after an appeal to the Upper Tribunal from another First-tier Tribunal. The President of Scottish Tribunals has asked that the decision in the case, **New Lanark Trading Limited v Office of the Scottish Charity Regulator** [2019] UT 62, be shared with legal members, and I am therefore drawing it to your attention.

Lord Tyre commented:

> *I would reject any suggestion that a different or lesser standard of reasoning applies to the decision of a tribunal as opposed to the decision of a court….the FTT was acting in a fully judicial capacity, and dealing with an issue that was of sufficient complexity to require more than a brief and summary decision. The adequacy of its reasons must be judged accordingly.*
>
> *…I am of the opinion that the FTT has not provided proper, adequate and intelligible reasons for its decision, because it has failed to address the point truly at issue between the parties.*

Finally on training, we noted the many positive comments about Jonny Benjamin's contribution to the conference. If we can, we will include input from someone with lived experience at this year's training too.

You will all be aware that there are or have recently been **independent reviews** which are relevant to the work of MHTS. Currently, John Scott QC is chairing a review of the 2003 Act. There will be a Call for Evidence by the Scott Review in the Spring. I would urge members to read it, and to consider responding as an individual or passing your thoughts to the President's Office. It is likely that, although we cannot take a view on what policy should be, the Tribunal as a whole will submit comments, derived from our experience of cases and the practical and legal issues that they raise.

Turning to the practical matters which regularly crop up within our administration, I would remind you of the need to look at papers as soon as you can after receipt, so that any **conflict of interest** is recognised and a replacement member identified. I would also reiterate that, even if you have only been booked for a half-day hearing, the other half of the day remains available – and only available – to MHTS. We are now achieving **double hearings** in about two thirds of cases, which is highly efficient, and we can only do that if the spaces remain open for second bookings. Of course, 'doubling' relies on flexibility of members, and their willingness to travel between venues in the middle of the day. We are all very grateful for such a high level of commitment.

Turning to engagement with members, I have to admit that I did not manage to speak to as many of you as I had hoped at the conference in November. It turned out to be quite a busy day. But I plan to keep at it. So far this year, I have already visited Inverness, to meet members at the **Highland and Moray Forum**. Not everything suggested at such gatherings can be implemented, and some is not within my power to deliver. I can, however, advise that the request for afternoon hearings in Elgin to be brought into line with the other hearings in the area by starting at 1.30 pm rather than 2 pm is going to happen. I will be visiting **Aberdeen** in March, and **Tayside** later in the Spring, so do please think of points you wish to discuss (and consider again the fact you are going to tell me about yourself when we meet).

Finally, it remains only for me to record appreciation of all that you do in your roles within MHTS. Starting as President has given me a far greater insight into the overall picture: the ceaseless work by the administrative staff, often under pressure, the variety of applications, the extent of the activity every day and the dedication of members and clerks who make their way to hearings all over the country. They do their best to deliver an experience which is as positive as it can be for the person at the centre of it, and for their family, representatives and professionals involved too. Thank you.

With best wishes
**Laura J Dunlop QC, President**

# Tribute to Calum Grierson

## by Calum's colleagues

Calum started work in the MHTS in July 2006 as a Hearings Clerk after taking retirement from South Lanarkshire Council where he had a long career in Human Resources. Calum finished working with the Council on the Friday and started with the MHTS on the following Monday showing his strong work ethic, something which became apparent to all of his colleagues throughout his 13 years working with the MHTS.

Calum was a popular member of staff who made many great friends throughout his time with the MHTS. He was very kind and generous and would always make a point of speaking to new staff, making them feel welcome. Calum was also well known for being a bit of a character and enjoyed playing practical jokes on his colleagues. Calum had a great relationship with the tribunal members, who he often spoke of fondly, and was always the ultimate professional when carrying out his duties as a clerk.

Outside of work Calum was a proud husband to Irene, dad to Paul and Scott and papa to Max, Maisie and Mia. Calum also had a great relationship with his daughters-in-law, Nikki and Claire. Calum was a family man who loved spending time with his family, going on holidays and weekend trips to the caravan. He also had a wide circle of friends with whom he enjoyed socialising on a regular basis, including days out and travels abroad with the Tartan Army to watch his national team.

It was well known that on the last Friday of every month Calum spent the night socialising with friends in the Clutha bar in Glasgow. It was on one of those nights, in November 2013, that Calum was involved in the terrible helicopter accident in which sadly he lost one of his friends. However, Calum's strong character and work ethic being as it was, he returned to his duties in the MHTS quickly the following year.

Calum will be sadly missed by all his colleagues, staff and tribunal members alike. He was always a friendly face and enjoyed a catch up with everyone he met.

# News

## Venue Update

### Skye House

The entire unit at Skye House is currently being painted, including the group room used by the Tribunal.

In response to reports of issues in relation to privacy and noise which was distracting to panel members, MHTS has requested that the disturbance at the times of hearings be kept to a minimum.

The hospital has noted other concerns raised by members, for example about dirty tables. MHTS will continue to monitor the situation.

### Elgin and Seafield

With immediate effect, afternoon hearings in Elgin and Seafield will start at **1:30pm** instead of 2:00 pm, to bring this in line with other remote venues.

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## Scheduling Update

### Expenses

A number of members continue to contact the Scheduling Team with regard to expenses. Members should please note that all enquiries in relation to expenses should be directed to Jim Hunter, who is available to contact between 10am and 3pm:

Email: webrosterexpenses@scotcourtstribunals.gov.uk

Telephone: 01698 390090

### Availability of Members

Members are asked to note that if they provide availability for hearings, they must be available for the full day.

The Independent Review of Learning Disability and Autism in the Mental Health Act published its final report on 18 December 2019 and submitted it to the Scottish Government.

You will find a copy of the Report here: https://www.irmha.scot/final-report/

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# Grampian Members' Forum

**Date:** **Thursday, 12 March 2020**

**Venue:** **Tribunal Suite 1, Bennachie Building, Royal Cornhill Hospital**

**Time:** **6 pm**

**Speaker:** **Derek Auchie will be giving an update on the new Rules**

Tea and Coffee will be served.

**Laura Dunlop QC, President**, will also be attending the forum to meet with members.

**Please advise the forum organiser, Paula Fogiel, direct if you are planning to attend.**

**All welcome.**

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# Tayside Members' Forum

**Date:** **Thursday, 30th April 2020**

**Time:** **6pm**

**Venue:** **Tribunal Suite, Murray Royal Hospital, Perth, PH2 7BH**

**Speaker:** **Laura Dunlop QC, President**, will discuss Tribunal business and answer members' questions

**Please contact David Gilling by email to confirm attendance at:**

david.gilling@careinspectorate.gov.scot

# Members' Conference 2019


Mental Health Tribunal for Scotland
The Rt Hon
Lord Carloway
Lord President
Closing Remarks

# MHTS Reference Groups

As you will be aware, the Tribunal holds meetings throughout the year at different places in Scotland to share information and best practice and receive feedback from those involved in Tribunal proceedings. The Tribunal meets with patients, carers, advocacy workers and mental health professionals.

Dates of meetings planned for 2020 are as follows:

## Professional Reference Group / Service Users' and Carers' Group

- Wednesday 11 March 2020 in Glasgow
- Thursday 28 May 2020 in Perth
- Wednesday 26 August 2020 in Aberdeen

## Advocacy Reference Group

- Wednesday 3 June 2020 in Dundee
- Thursday 1 October 2020 in Hamilton

If you know of anyone who might be interested in attending one of these meetings, please ask them to contact the Tribunal at:

mhtsstakeholdergroups@scotcourtstribunals.gov.uk.

Further information, including Notes from previous meetings, can be found on the MHTS website:

https://www.mhtscotland.gov.uk/mhts/Reference_Groups_and_Forums/Reference_Groups_and_Forums.

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# MHTS RMO/MHO Forum

The joint RMO/MHO Forums are held by the Tribunal twice a year at the MHTS office in Hamilton.

The next Forum is scheduled to take place on

- Monday, 27 April 2020 at 12 noon in Hamilton House, Hamilton

If you know of a RMO or MHO who is interested in attending the Forum or if you have an item for the Forum Agenda, please contact **Yvonne Bastian** in the President's Office for further details.

Notes from previous RMO/MHO Forums can be found on the MHTS website:

https://www.mhtscotland.gov.uk/mhts/Reference_Groups_and_Forums/RMO_MHO_Forums

# Articles

## Hearings and the Law

There are two points to highlight in relation to the law applicable to MHTS and its hearings.

### 1. Accessing the legislation at hearings

If you wish to examine a particular statutory provision during a hearing, there are (at least) four ways to do so:

*Option 1*

From the MHTS website directly – the tab 'Legislation and Caselaw' will take you to a page where there is a link to the 2003 Act on the legislation.gov.uk website. (http://www.legislation.gov.uk/asp/2003/13/contents) This is an up-to-date version of the Act. The Rules can be found by logging into the Members' Area, where there is a version of the Rules currently in force, courtesy of Westlaw:

SSI 2005/519 – Law in force (Westlaw)

This remains an accurate version of the Rules.

*Option 2*

By downloading the above versions of the Act and the Rules to your own laptop, using the links provided, for use at hearings when internet access is not available. Alternatively, you could place these on a memory stick, for use at hearings.

*Option 3*

All Clerks have up to date versions of the Act and the Rules on their laptops. They can therefore assist with finding a particular section or rule.

*Option 4*

The second edition of the book, '*Mental Health (Care and Treatment) (Scotland) Act 2003'*, a copy of the Act with extremely useful annotations by Ronald Franks and David Cobb, is available for purchase at a cost of £100 from bookshops or the usual websites. A discount is available if you buy from the law bookshop, Avizandum, in Edinburgh, making the cost of the book £92.50, with free postage and packing: 0131 220 3373, www.avizandum.co.uk.

### 2. Standard of decisions

As referred to in the President's Foreword, there has been recent adverse comment on the quality of a tribunal decision. This did not emanate from MHTS, but the principles applicable were there to be a challenge of the reasoning in a MHTS decision would be similar. All members, and legal members in particular, are encouraged to read the case, *New Lanark Trading Ltd v OSCR* [2019] UT 62.

# Interim orders and independent medical reports

As you may be aware, the casework teams meet regularly with me or with an In-house Convener, for case management. This gives us the chance to look at any particular challenges or patterns which emerge in cases. At the moment, there are two areas under examination; the interim order and the instruction of an independent medical report by the tribunal. Both of these steps are perfectly competent, and there can be no general rule as to when they will, or will not, be taken. However, one of our objectives as a tribunal service is to minimise delay and to keep to the overriding objective set out in Rule 4 of the 2005 Rules, whereby proceedings should be handled as fairly, expeditiously and efficiently as possible. Of necessity, adjournment prolongs the time taken before issues are resolved.

At times, it will be obvious that a decision cannot be taken on the day, for example if a witness or a party isn't present, or if important information isn't yet available. The patient's or named person's solicitor may require more time to prepare. At that point, an adjournment is going to be necessary and, in an application for a CTO or CO, it is likely that an interim order will also be required to facilitate that. Clearly, the tribunal can't determine whether the statutory criteria for imposing a full CO or CTO are met in such cases. However, there are a few adjournments which might fall into more of a grey area. What follows refers to that 'grey area'.

Casework teams have noticed that some panels have held off making a full order because the patient's mental health may be improving and approaching the point where it is possible that the criteria will not be met. Then, an interim order is imposed to allow a short period for this to continue, presumably in the hope that a full order will not be required. Whilst this is done for positive reasons, it may leave us vulnerable to challenge. So, as a quick reminder, it's worth noting that the tribunal must consider the evidence and reach a decision as at the date of presentation. There is no provision within the tests set out in section 64 to consider whether they will continue to be met at a point in the near future. If the tribunal is satisfied on the evidence that the patient, on the day of the hearing, meets or continues to meet the statutory tests for imposition of the relevant order, there is no need to adjourn or to impose an interim order. If rapid progress is made by the patient towards better mental health (which is, of course, the outcome we are hoping for) then there are provisions for the RMO to reduce the level of intervention in the patient's life. This may, for example, be through suspension of detention, or through revocation of the order itself. There is no need for the panel to attempt to foresee any changes. Another way of looking at this would be to consider it from the opposite perspective: if a patient was deteriorating but did not on the day of the hearing meet the criteria for compulsory treatment, you wouldn't consider making an order in anticipation of the patient meeting the criteria at a point in the future. In short, if the patient meets the criteria on the day of the hearing, and there is sufficient evidence for the tribunal to be satisfied of that, there is limited discretion available to you as a decision maker. If the criteria are met, the order should be made, in full. If they are not met, the order cannot be made. If there is insufficient evidence for the panel to determine whether or not the criteria are met, then you are into the territory of adjournment and interim order.

Similarly, the tribunal is empowered to instruct that an independent medical report be provided. This is (or at least should be) a fairly unusual step. The power exists to address situations where there is not enough evidence either for or against the criteria being met. That is a situation that should arise infrequently. The panel will hear oral evidence and/or see written evidence from the patient's RMO and MHO, and if there is any contradictory evidence, it will have either a written independent medical report or a witness to provide that evidence. Whilst it may be difficult to balance the evidence from different sources and to prefer one account over another, the answer will rarely be to look for another, fresh source of evidence. The tribunal's role is to work through the evidence available. The tribunal can use the semi-inquisitorial function to test evidence, to question witnesses and to satisfy itself as to whether the relevant tests are met. It should be a rare situation where that cannot be done and where a further medical report is required. If you as a panel think that you might be entering that territory, before instructing the report, consider what further information is actually required to determine whether the statutory tests are met. Is it something that realistically can be provided by an independent medical expert, or is it something that the RMO (or the patient's existing expert witness) could reasonably be expected to provide? In short, what element is missing from the evidence? What question needs to be answered? If that can be identified and, if it is reasonable to expect that to be provided by an expert report, then in those circumstances it may be appropriate to consider instructing such a report. At this point, sufficiently clear and detailed instructions to the expert from the panel will be essential. You will have to ensure that the independent medical expert is aware of that question, and of what you consider it is necessary for the tribunal to know in order to answer it. This should result in a report which will actually fulfil the evidential requirement.

Ultimately, additional independent medical reports require a further examination of the patient, on at least one occasion. That may be intrusive and unwelcome, it may be disruptive to the patient, or to the patient's relationship with the treating team, and it may cause distress. As has happened, the patient may refuse a further examination (which will put the tribunal in a difficult position, if that really is the only way the panel believed that they could reach a decision). In some cases, the report when finally received does not actually address the specific gap in evidence.

In short, a panel should instruct an independent medical report only when it is absolutely essential, and with sufficiently specific instructions in an appropriately worded Direction to allow the author to provide the missing piece of evidence required. If it can be determined on the balance of probabilities whether or not the statutory criteria are met without this type of report, the legislation requires the panel to make a full order or refuse the application accordingly.

Finally, when making a compulsion or compulsory treatment order, it is important to remember the purpose it serves. It is a necessary pre-requisite to providing care and treatment and, in some circumstances, to detaining the patient for this care. It is of course not all that is required: a suitable care plan, appropriate accommodation and compliance by the RMO with the requirements for medical treatment as set out in Part 16 of the 2003 Act may also be required. The absence of any other necessary pre-requisite to treatment does not mean that no order can be made. If the relevant criteria are met an order must be made. Consideration may also be given as to whether a recorded matter is required.

**Jennifer Whyte**
**Legal Secretary**

# MHTS Conference Workshops

What follows is an overview of the five workshops which took place at the MHTS Conference 2019, with grateful thanks to the author of each.

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## Are the principles of the 2003 Act compatible with human rights today?

This was a brain-stretching, challenging workshop in which the admirable Cathy Asante of the Scottish Human Rights Commission outlined the principal human rights developments since 2003. Of special relevance is the UN Convention on the Rights of Persons with Disabilities (CRPD, 2006) with its focus on the social model of disability and the right to legal capacity and supported decision making (Articles 5 and 12).

These are not just noble aspirations. Cases before the European Court have reviewed, for example, the ways in which 'the best interpretation of the will and preferences of a person with a disability' are determined. Reliance solely on the 'best interests' principle is no longer a safeguard in such determinations. The CRPD Committee does not interpret Article 12 as precluding some decisions being made for a person but it does invite States to rethink how such decisions are made in exceptional circumstances. So are we content that current interpretations of the principle that the patient's past and recent wishes must be taken into account comply with Article 12? Advocates' contributions can be admirable in this respect; so can those of family members, but do tribunals always analyse these with sufficient care? And does the practice of all curators *ad litem* live up to this standard? And in tribunals which involve a person with a learning disability, are we confident that information to that person is delivered in an understandable and accessible manner?

We could only touch on such matters because we were so absorbed by the challenges presented by CRPD to our interpretations of the principles of maximum benefit, least restriction and reciprocity. These arise from a recent case before the Court – *Rooman v Belgium* (18052/11). The determination stated 'it is necessary to recognise explicitly that there exists an obligation on the authorities to ensure appropriate and individualised therapy…any detention of the mentally ill person must have a therapeutic purpose….irrespective of the facility in which those persons are placed they are entitled to be provided with a suitable medical environment accompanied by real therapeutic measures…..mere access to health professionals…..and provision of medication cannot suffice for a treatment to be considered appropriate and satisfactory under Article 5…'.

In our workshop we recalled cases in which we were unsure about the extent and quality of care provided. In these circumstances what should now be the tribunal's role? If services available do not meet the standards seemingly required by CRPD do we record this in our determinations; make Recorded Matters; refer such matters to the Mental Welfare Commission? Many of us regard the Act's principles as its most precious component. On the face of it, they seem to fit well with CRPD; but does the MHTS need now to consider how they should be interpreted? This hugely demanding task needs further consideration and the excellent material provided by Cathy should receive the attention it deserves.

**Juliet Cheetham**
**General Member**

## Creativity and Hope in Dementia Care

Arriving at the workshop given by Dr Margaret Brown and Dr Barbara Sharp, University of the West of Scotland, we participants knew immediately we were in for a multi-sensory experience because of the tables laden with facsimile ten shilling notes, glasses with peculiar covers, earphones, picture cards of past scenes, armoured gloves and the like.

Our two presenters introduced themselves and launched into the complexities of dementia. The paradigm of 'challenging behaviour' was dispelled and a different one of 'stress and distress' preferred, i.e. such behaviours are reactions to stress and/or distress. 80% of distress is caused by touching. With impaired cognition, touching is seen as invasion or threat. The workshop theme had a lot to do with understanding the dementing person's perception of approach and imminence of touch.

To help us to see/hear/sense the person's world the glasses gave us a sense of what it is like having macular degeneration (and losing central vision), cataracts (with vision becoming milky and blurred) and a hemianopia (losing one half of the visual field); the hearing muffs the distortions in sound; and the B & Q armoured gloves the difficulties with activities involving touch and picking up and handling small objects or fine material.

One lesson: recognise the person's physical problems. General or focal loss of power or sensation may occur, e.g. loss of extension of the arms being the usual and hence easier dressing someone with a back opening shirt. In washing, problems with water all over the place can be avoided with clever plastic caps that need just a spoonful of water to wash the hair. The use of low foam, non-flavoured tooth-paste applied with a specially configured brush not to jab gums and buccal linings take the threats out of cleaning and prodding the mouth, probably the most sensitive part of our anatomy.

Another lesson: people don't stop being complex because they begin to dement. Thus the person might still maintain a front even with the onset of dysphasia and there may be tears behind the smiling, silent facade or insight into brain fog behind a blustering front.

A third lesson: everybody has a story. Help the person to tell their story, ask the family to fill in a structured template of their relative with his/her achievements, family, work, loves, likes, humorous sayings, and so on. Apart from the stories' fun and interest, we will then know who we're approaching, what they enjoy, what makes them relax/smile/get upset and so on.

A fourth lesson: how to bring the person with you for some of these personal tasks, e.g. can you persuade them they're doing it for you (rather than you doing something to them); or can you use implicit memory, e.g. when feeding a person, ask them to grip your wrist so that as the spoon approaches the mouth implicit memory suggests the thing to do is to open the mouth!

Sensory Based Care Practice is clearly a passion for the teachers at our workshop. Examples were shown of the delights music and dancing can bring to one individual, while another loved arranging flowers (the carer is not to take over the arranging), and another loved her nails being treated, polished and admired. Twiddle muffs may keep the person from fiddling with a drip or bandages on the arm.

The pièce de resistance of the afternoon was the dementia doll. After telling us not to hand people dolls ('let them pick them up'), our facilitators allowed this lifelike doll to be passed around with the clear message that this may also unlock and free up communications about past lives.

**Dr Jim Craig**
**Medical Member**

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## Law and Ethics

"Seems straightforward" are the forbidden words never to be uttered by tribunal members before a hearing. The five case scenarios presented for discussion by Professor Margaret Ross and Dr Susan Stokeld, University of Aberdeen, were anything but straightforward.

First up, review of a CTO in which the reports contain poor quality hearsay evidence for which there seems little, if any, factual basis. Second, a 14-year old learning disabled girl located inappropriately in an acute adult ward where the use of physical restraint leads the MHO to seek a CTO to regularise her care and treatment. Third, an appeal to the Sheriff Principal by parents of a young man with schizophrenia against the measures contained in a community based CTO. The measures are said to prevent their son fulfilling religious observance at specified times of the day and week. The parents also request patient anonymity in the Sheriff Principal's written decision. Fourth, an application to revoke a STDC in respect of a French-speaking woman with dementia for whom community-based treatment has broken down. Finally, an appeal against a soon-to-expire STDC in respect of a young girl with anorexia and a learning disability. The bad weather has prevented all but the patient, MHO, tribunal clerk and the medical member from attending. Can the convener, general member and RMO participate by telephone?

This session was a workshop with each table allocated one of the above cases. A variety of questions arose. What can tribunals do to assist meaningful patient participation? How can we best address interpreter problems? How should tribunals deal with poor quality evidence? Do full findings and reasons need to be more (or less) anonymous? To what extent should the tribunal involve itself in issues such as quality of care and adequacy of resources? And of course, what can we do about the weather? There was plenty to discuss.

**Dr Derek Chiswick**
**Medical Member**

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## Learning Disability

The workshop was taken by Linda Mitchell and Catriona Rowley of the Scottish Commission for Learning Disability. The Commission works to deliver a range of projects aimed at implementing 'The Keys to Life' and representing the views of those with learning disabilities to the Scottish Government.

The term '*learning disability*' covers a broad spectrum of disabilities and therefore represents a wide variety of people. The broad reach of the term means it is difficult to ascertain a communication strategy which caters for all individuals included in the umbrella term. This presents those coming into contact with people with learning disabilities with a challenge in finding a suitable and effective communication method for each individual.

‘The Keys to Life’ is Scotland’s learning disability strategy which was launched in 2013. The strategy was developed by the Scottish Government with COSLA and a wide range of statutory and third sector partners, together with people with learning disabilities and carers. The strategy has a strong focus in tackling the significant health inequalities faced by people with learning disabilities. Central to the strategy are the principles of choice, control and independence for people with learning disabilities.

The workshop focussed on the challenges faced by those with learning disabilities. To illustrate those challenges 8 workshop participants were asked to stand in a line and take steps forward on their ‘life line’ when a question asked applied to them. Participants were asked questions including: “Have you ever been bullied?”, “If you had a baby do you think you would be able to keep it?”, “Do you decide your own bedtime?” and “Do you ever need help with understanding things?”. The participants moved across the room illustrating the progress they have made on their ‘life line’. We were then shown a video of a group of people with learning disabilities participating in the same exercise. They were not able to answer ‘yes’ to many of the questions, resulting in them remaining relatively close to the start of their ‘life line’, illustrating the many hurdles those with learning disabilities face throughout their lives. For example, primary school children with special educational needs are twice as likely as other children to suffer from persistent bullying and about 50% of adults with learning disabilities who had a child had the baby removed from their care.

After the video it was explained that the exercise had been discussed in detail and rehearsed with each of the participants, however they answered some questions differently when being filmed. This highlights the breadth of challenges faced when communicating with those with learning disabilities. It is difficult to communicate in a method which can be easily understood and thereafter to ensure consistent and accurate information is communicated back.

Various methods were discussed to help ensure a person with learning disabilities can participate fully in the Tribunal process. Advocacy support was identified as helpful in providing a voice for a person with a learning disability who struggles to communicate clearly, particularly with people unfamiliar to them. However, research has shown that it is not effective for every individual as frequently the advocacy worker has not had the opportunity to meet with the patient on a sufficient number of occasions to get to know them well. Therefore, it was suggested that consideration could be given to allowing a person who knows the patient well to support them to communicate during the Tribunal process as they may be better placed to pick up on the individual’s methods of communication. However, caution must be exercised where the person offering support is a parent or carer, as it is frequently noted in research regarding decision making among those with learning disabilities that they often experience their decisions been made for them by those who care for them. Remaining mindful of language choice, question length and complexity, times the person is left waiting and ensuring that information is available in a way which the person can easily understand are all identified as useful tools when approaching a hearing with a patient with learning difficulties.

**Laura McLaughlin**
**Legal Member**

## Scottish Government's Mental Health Strategy 2017-27
## Perspectives Across Sectors

This workshop was delivered by the Chief Executive of the Scottish Association for Mental Health (SAMH), Billy Watson.

SAMH was established in 1923. It has a turnover of £19 million and supports nearly 5,000 people through over 60 community based services across Scotland. SAMH is the Managing Partner for 2 national programmes – **See Me,** the national programme for anti–stigma and discrimination, and **Respect Me**, Scotland's national anti-bullying programme.

The Scottish Government's "Mental Health Strategy 2017–2027" was launched in March 2017 following a consultation exercise and benefits from the work already carried out as a result of the Government's Mental Health Strategy 2012–2015.

Improving mental health is a priority for the Scottish Government.

Mental illness is one of the major public health challenges in Scotland. Around one in three people are estimated to be affected by mental illness in any one year.

The Government seeks to reform children and young people's mental health services; to take a 21st century approach to adult mental health; to respect, protect and fulfil rights; and to make suicide prevention everybody's business.

The 2017–2027 Mental Health Strategy sets out its guiding ambition to "treat mental health problems with the same commitment, passion and drive as we do with physical health problems".

In seeking to achieve parity between mental and physical health the "strategy" sets out 4 main strategic drivers…

- **Prevention & early intervention;**
- **Access to treatment, and joined up accessible services;**
- **The physical wellbeing of people with mental health problems;**
- **Rights, information use and planning.**

The 2017–2027 Mental Health Strategy seeks to deliver on 40 separate Actions, including 13 of which are specific to children and young people. It is outwith the scope of this article to list all 40 Actions but these are a few so as to provide a flavour of the Scottish Government's Mental Health Strategy:

- Action 7 – Support an increase in support for the mental health needs of young offenders, including on issues such as trauma and bereavement.
- Action 10 – Support efforts through a refreshed Justice Strategy to help improve mental health outcomes for those in the justice system.
- Action 12 – Support the further development of the National Rural Mental Health Forum to reflect the unique challenges presented by rural isolation.
- Action 15 – Increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons. Over the next five years increasing additional investment to £35 million for 800 additional mental health workers in those key settings.

- Action 19 – Commission Lead Clinicians in CAMHS to help develop a protocol for admissions to non-specialist wards for young people with mental health problems.
- Action 27 – Test and learn from better assessment and referral arrangements in a range of settings for dual diagnosis for people with problem substance use and mental health diagnosis.

Under Action 40, the Government will carry out a full progress review in 2022, the half way point of the Strategy, to ensure that lessons are learnt from actions to that point.

For those wishing to look further the Government's Strategy can be found at:

https://www.gov.scot/publications/mental-health-strategy-2017-2027/

**Duncan Charles**
**General Member**

# Useful Information

## Legal Update

### ❖ The 2003 Act and amendments

Members can access the *Mental Health (Care and Treatment) (Scotland) Act 2003* and links to amending legislation (including the *Mental Health (Scotland) Act 2015*) on the Tribunal's website under "**Legislation and Caselaw**".

The "Latest available (Revised)" version of the 2003 Act which is published on the www.legislation.gov.uk website now incorporates all changes to the 2003 Act to date. Any section of the 2003 Act containing future outstanding changes which still have to be incorporated will be highlighted in red with a reference to the relevant legislation effecting the change. The original version of the Act as enacted can also be viewed on the UK legislation website by clicking on "Original (As enacted)".

### ❖ The Mental Health Tribunal for Scotland (Practice and Procedure) (No. 2) Rules 2005

Westlaw has kindly given its permission for the MHTS to share the consolidated version of the Tribunal's Rules with members – to be found on the Judicial Members' webpage of the MHTS website: "SSI 2005/519 – Law in force (Westlaw)". Members may download and print a copy **for internal use only**.

### ❖ Statutory Instruments

Over 90 statutory instruments have been made since the 2003 Act was passed. A comprehensive list of all statutory instruments affecting our jurisdiction can be found on the Tribunal's website under "Legislation and Caselaw" – listed chronologically, alphabetically and by subject matter.

Members may wish to note that Tribunal Clerks have been issued with electronic copies of all statutory instruments, for ease of access by members to this secondary legislation at venues which have no internet connection.

### ❖ Case law

*New Lanark Trading Limited v Office of the Scottish Charity Regulator* [2019] UT 62.

## President's Practice Guidance

All practice directions and guidance which have been issued by the President to Tribunal Members and to the Administration are available in the Judicial Members' area of the Tribunal's website at:

https://www.mhtscotland.gov.uk/mhts/Members_Area/President_s_Guidance_and_Directions

# Informative Publications

- Event Report: SDS, Human Rights and People with Learning Disabilities

  https://www.alliance-scotland.org.uk/wp-content/uploads/2019/12/ALLIANCE-MECOPP-Masterclass-Report-SDS-Human-Rights-and-People-with-Learning-Disabilities-.pdf

## Mental Welfare Commission Publications

- Capacity, consent and compulsion for young people with borderline personality disorder – Good practice guide, published 3 October 2019

  https://www.mwcscot.org.uk/sites/default/files/2019-10/YoungPeopleWithBPD_GoodPracticeGuide_20191003_secured.pdf

- Use of seclusion – Good practice guide, published 10 October 2019

  https://www.mwcscot.org.uk/sites/default/files/2019-10/Seclusion_GoodPracticeGuide_20191010_secure.pdf

- Annual Statistical Monitoring, published 23 October 2019

  This report outlines data on the use of the 2003 Act during 2018/19. The report also includes a broader range of figures, and comparisons over the last ten years.

  https://www.mwcscot.org.uk/sites/default/files/2019-10/MHA-MonitoringReport-2019_0.pdf

- Visiting and Monitoring Reports – Scotland's mental health rehabilitation wards: themed visit report, published 30 January 2020

  https://www.mwcscot.org.uk/sites/default/files/2020-01/20200130_ScotlandsMHRehabWards_ThemedVisitReport_0.pdf

- Mental Welfare Commission for Scotland Stakeholder Survey

  The Mental Welfare Commission for Scotland has launched a stakeholder survey seeking feedback on its roles and work. The aim of the survey is to gather the views of people who have been in touch with the Commission, either on a personal or professional basis.

  https://www.smartsurvey.co.uk/s/MWCSurvey/

**Please note that links to Informative Publications are included for information only. Any views expressed in these publications are those of the authors and not those of the MHTS.**

**The Newsletter is available on the Tribunal's website:**

**www.mhtscotland.gov.uk**

## Newsletter Contributions

The Tribunal welcomes contributions to the Newsletter from all members. Members who wish to contribute to the Newsletter should contact Yvonne Bastian at MHTSPresidentsOffice@scotcourtstribunals.gov.uk

**Contributions must be typed in Arial, font size 12, with justified margins, and with necessary references set out as footnotes.**

The following timescales will apply for contributions*:

**May edition:** contributions by the end of March

**September edition:** contributions by the end of July

**January edition:** contributions by the end of November

***Contributions may require to be edited**

# Useful Contacts

## Scheduling Team

**(including re-setting Webroster and MHTS Website passwords)**

schedulingmhts@scotcourtstribunals.gov.uk

- Telephone: 01698 390073

## e-Expenses Helpdesk

webrosterexpenses@scotcourtstribunals.gov.uk

- Telephone: 01698 390090

## Finance Team

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- Telephone: 01698 390054

## President's Office

mhtspresidentsoffice@scotcourtstribunals.gov.uk

**Fiona Queen, PA to President and Member Liaison Officer**

- Telephone: 01698 390033

**Yvonne Bastian, President's Office Secretary**

- Telephone: 01698 390001