Mental Health Tribunal for Scotland

Annual Report 2012

Contents

SG/2012/••

President's Foreword

President, Dr Joe Morrow

I have the pleasure of presenting the Annual Report for the year 2011/2012 for the Mental Health Tribunal for Scotland (MHTS). The Report covers a year of progress in terms of our commitment to focus on the patient and to continue to improve our activities. The Report affords me an opportunity of recording my thanks to the Tribunal Members and the administrative staff of the Scottish Tribunals Service (STS) for the commitment, energy and professionalism they all put into the work of MHTS.

The work of MHTS involves significant decision making about the detention and compulsory treatment of individuals with mental disorder. Our approach in the Tribunal is to focus on the care and treatment of the patient, a central part of which is obtaining the patient's views. The training of Tribunal Members and staff is geared towards ensuring that those views are heard. This process is greatly enhanced by the work of advocacy services throughout Scotland. At a time when a person may be having his or her liberty restricted and being treated compulsorily for mental disorder, the role of advocacy is important in helping that person understand the processes which he or she is at the centre of and explaining clearly views about outcomes and, if necessary, treatment. The publication of the *Mental Health Tribunal Advocacy Guidelines* is a welcome contribution to strengthen good practice in this field.

I have concentrated my work in the last year on bringing additional efficiencies and increasing effectiveness to the activities of MHTS. This is shown by the reduction in the number of hearings required for a case to progress through the Tribunal process. It is my view that when a person's liberty is at stake, it is appropriate to properly focus the decision making, and I am committed to continually refining our case management in order to ensure that cases come only once before a Tribunal where appropriate.

The work of MHTS continues to be placed firmly in the context of the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Millan principles which are embedded in section 1 of that Act. I have worked towards a practical and common-sense approach to the application of the 2003 Act. The Tribunal, and Scottish life in general, cannot remain static. The culture of improvement leads the Tribunal into new initiatives, such as the Scottish Government's proposals on tribunal reform. These proposals remain focused on users and the principles within the 2003 Act, but also on

ways to improve the Tribunal's engagement with mentally disordered people and their families, as well as the professionals who appear before MHTS on a daily basis.

The achievements set out in this Report could not have been achieved without the high level of commitment by all those involved in proceedings before the Tribunal. The number of interim orders, adjournments and sitting days have all been reduced in the last year. These facts impact on the whole system of mental health services in Scotland and highlight the need for an appropriate and proportionate decision-making process within the area of our responsibilities. Some of the work which was piloted in the year 2010/2011 has been mainstreamed. One example is that the Triple Hearings piloted at some of the hearing centres with high volumes of cases have now become mainstream. This has contributed to our understanding of how best to use judicial time at a Tribunal.

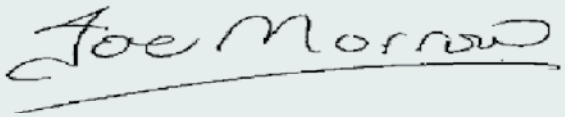
The Tribunal Membership and the STS staff continue to provide a high level of service to the Tribunal, focused on just outcomes for patients.

In Scotland, our approach to this area of work has been acknowledged as an exemplar and demonstrates the importance of a high degree of scrutiny, independence and sensitivity in dealing with the detention and compulsory treatment of those with mental disorder. This Report shows how this has remained a core part of our work and, in my view, has further enhanced the reputation of Scottish mental health law.

This year's Report highlights the specialist nature of the Tribunal. It shows the high level of knowledge and experience which is brought to bear in this important work, and it should be noted that the specialist training of our Members and staff enhances this specialist nature of the Tribunal. The specialism of the Tribunal rests in the Membership and their training, which therefore remains central in my approach to our future work.

The McManus Review amendments to the 2003 Act do not yet have a legislative slot in the Parliament. We await the progress of these amendments, which will bring further opportunities for new improvements to the mental health tribunal system.

Finally, the patient remains at the centre of our activities, and I will work to make sure that this continues to be the case in the year ahead. The need for a specialist tribunal to deal with the weighty matters of detention and compulsory treatment of mentally disordered people is clearly set out in the Millan Report and the subsequent 2003 Act and remains relevant for the administration of justice in this area today.



Dr Joe Morrow
President

A specialist tribunal

The Mental Health Tribunal for Scotland ("the Tribunal") is a specialist tribunal. This is sometimes also referred to as being an expert tribunal. The Court of Session acknowledged that the Tribunal is a specialist tribunal in its Opinion in the case of **Scottish Ministers v MHTS (JK)** 2009 SC 398. In **JK** the Court stated "It [the Tribunal] is of course, a specialist tribunal and regard has to be had to its expert knowledge".

The President of the Tribunal views the specialism of the Tribunal as a particular strength in the consideration of cases involving applications etc for compulsory measures of care and treatment of individuals with mental disorder and is committed to ensuring that this expertise should be retained in any reform of the tribunal system in Scotland.

What does the term "specialist tribunal" mean?

The Tribunal is a specialist tribunal as each individual Tribunal requires to consist of 3 Members – a legal Member, a medical Member and a general Member. The Scottish Ministers have made regulations which prescribe the qualifications which a person must satisfy before being eligible to be appointed as a legal, medical or general Member.

Legal Members must be qualified lawyers for at least seven years. The legal Member acts as the convener of the Tribunal. In restricted patient cases (i.e. the cases of certain patients who have entered the mental health system through the criminal justice system), the convener requires to be the President of the Tribunal or a sheriff. Medical Members must be medical practitioners who are Members or fellows of the Royal College of Psychiatrists or who have at least four years experience of providing psychiatric services. General Members must be people who have a mental disorder or a person who cares for a person with mental disorder; nurses, social workers or occupational therapists who have experience of working with people with mental disorder; clinical psychologists or people employed in, or managing the provision of, a care service to people who have a mental disorder.

An individual Tribunal comprises three Members bringing together expertise in the areas of law, medicine and the care and treatment of mental disorder. The Tribunal's decision making is based on a multi-disciplinary approach and each Member of the Tribunal has an equal vote in relation to the decision ultimately made by the Tribunal. The Tribunal Members can use their specialist knowledge in Tribunal proceedings e.g. in the interpretation and evaluation of evidence or by asking appropriate questions informed by their expertise to clarify or elicit relevant evidence. The Tribunal must however take care not to use the knowledge of the medical or general Member to fill in gaps in the evidence before the Tribunal.

What relevance does the fact that the decision was made by a specialist tribunal have when a decision of the Tribunal is the subject of an appeal to the Courts?

This issue has been considered by the courts in other jurisdictions. In **AH and Others (Sudan) v Secretary of State for the Home Department** [2008] 1 AC 678, which considered an appeal against the decision of an Asylum and Immigration Tribunal (AIT), the House of Lords noted that the AIT was an expert tribunal and the courts should approach appeals from such tribunals with an appropriate degree of caution. Baroness Hale of Richmond noted that it is probable that in understanding and applying the law in their specialised field the tribunal will have got it right. She emphasised that it is for the expert tribunal alone to judge the facts and that the decisions of such tribunals should be respected unless it is quite clear that the tribunal has misdirected itself in law.

The appeal courts will be slow to interfere with decisions on matters within the special expertise and competence of an expert

tribunal but while acknowledging the tribunal's expertise the courts will have no hesitation in overturning the decision of a tribunal when it is clear the tribunal has erred in law. This approach can be seen in the **JK** case referred to above. While acknowledging the specialist nature of the Tribunal the Court allowed the appeal on the basis that the Tribunal had erred in law in making the decision.

CORO cases

A small number – and it is important to note that it is a small number – of patients who come within the jurisdiction of the Tribunal enter the mental health system through the criminal justice system. Patients in respect of whom a criminal court imposes a compulsion order and a restriction order (CORO) form part of that number.

Where the court imposes a compulsion order alone it authorises detention in hospital and the giving of compulsory treatment for up to 6 months (unless the compulsion order is extended by the Tribunal after hearing an application to do so by the responsible medical officer (RMO)). However, where the court imposes a compulsion order (CO) and is of the view that if the patient was unwell in the community the patient would pose a risk of serious harm to the public the court will also impose a restriction order (RO).

Where a patient is subject to a CORO the patient's case falls to be dealt with in accordance with Part 10 of the Mental Health (Care and Treatment) (Scotland) Act 2003. This has a number of important effects.

First, certain aspects of the patient's care (such as suspension of detention to allow the patient to be "tested out" in the community) are subject to the scrutiny of the Scottish Ministers to ensure that there is oversight of decision making by mental health professionals concerning the patient's progress through the mental health system.

Second, when a CORO patient's case comes before the Tribunal the Scottish Ministers are entitled to lead and produce evidence, in addition to the patient, the patient's named person, RMO, mental health officer (MHO) and any curator *ad litem*, guardian or welfare attorney.

Third, it is for the Tribunal alone, on the basis of the documentary and oral evidence before it and submissions made to it, to decide whether to conditionally discharge the patient into the community (and, if so, to decide what conditions to impose); to decide whether to revoke the patient's restriction order (removing the oversight role of the Scottish Ministers in respect of the patient and leaving the patient subject only to the compulsion order for 6 months, unless the compulsion order is subsequently extended by the Tribunal on an application by the RMO); or to decide to revoke the compulsion order (effectively absolutely discharging the patient, because revocation of the compulsion order causes the restriction order to cease to have effect).

All cases before the Tribunal involve, amongst other factors, an assessment of risk. Commonly that assessment concerns risk to the welfare of the patient. Often it concerns assessment of risk to others.

There is no mystery to CORO cases, but there are differences between how CORO cases and other cases before the Tribunal are handled. Given that a restriction order is imposed by the court because of the risk of serious harm to the public if the patient was unwell in the community, the assessment of risk is often the area of greatest dispute between the parties before the Tribunal in CORO cases.

CORO cases – like any other case before the Tribunal – are heard by a panel of three. The panel comprises a general Member and a medical Member but is convened by either the President of the Tribunal or a sheriff, rather than a Member of the Tribunal's legal panel.

Appeals against decisions of the Tribunal in CORO cases are taken direct to the Inner House of the Court of Session, rather than to sheriffs principal. Only a small number of such appeals have been taken and the Tribunal has benefited from the Opinions of the Court of Session in those appeals, the most important being that in the appeal taken by the Scottish Ministers in the case of **JK**.

CORO cases can have particular sensitivities arising from the circumstances in which CORO patients entered the mental health system. As with all cases which fall within its jurisdiction,

the Tribunal endeavours to put the patient at the centre of its work while taking into account the views of others, which in CORO cases may include those who have been subject to criminal actions on the part of patients while unwell.

The work of Tribunals in CORO cases – as in other cases – involves the careful handling and balancing of sensitive, often distressing, facts and circumstances. The Tribunal provides training to general and medical Members to equip them to hear CORO cases and has a programme of ongoing development for the President and for sheriffs who convene CORO cases to keep them up to date with developments in the law.

Child and adolescent tribunals

Background

The Tribunal hears on average 60 applications, reviews or appeals in relation to young patients who fall within the age range of 10 to 17 years. Of these, the most common are applications for compulsory treatment orders, under section 63 of the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the Act"), followed by 2-year reviews conducted under section 101(2)(b) of the Act. The majority arise within Greater Glasgow Health Board, followed by Lothian, for young patients who fall within the age range 14 to 17 years (239 for children aged between 16 to 17 years and 94 for children aged between 14 to 15 years)[1].

Legislation

Section 2 of the Act specifies that any person discharging a function under the Act in relation to a patient who is under the age of 18 years requires to discharge the function in the manner that appears to the person to be the manner that best secures the welfare of the patient. Section 2 refers also to those statutory principles set out in section 1(3) of the Act and Tribunal Members must also have regard to these when deciding a case involving a patient who is under the age of 18 years.

Training

In order to meet the Tribunal's statutory duties, the President decided towards the end of 2011 that it was desirable to provide specialist training to a number of Tribunal Members, for child and adolescent tribunals. An application process was prepared in December 2011 and Members who met the set competencies were invited to apply for a limited number of places on the training. Twenty-six Tribunal Members from across the three disciplines attended a training day for this purpose on 28 March 2012.

The training focused on the section 2 and section 1 statutory principles; listening and communicating with young patients; and child and adolescent psychiatry. Members were provided with an opportunity to reflect on practices within two other jurisdictions, namely the children's hearing system and family actions in the sheriff court. Young mental health service patients' views were captured through patient, named person and advocacy participation in the training. Feedback from Members who attended the training was very positive.

Some of the emerging themes were:

- Some patients can find the venue layout and environment stressful and difficult.
- A parent of a patient commented that her daughter felt the Tribunal Members were very far removed from her and all of them appeared to be over the age of 60. The impression was that they may therefore be unable to empathise with the patient.
- The fact that a young patient can only have one named person, despite having two parents.
- The difficulties in obtaining the views of the patient where s/he decides to remain silent at the hearing.
- The importance of maintaining judicial boundaries in the hearing and not causing identity confusion for the patient.
- The variance in practice among conveners regarding how they hear the evidence of the patient.
- The advantages of the RMO providing a clinical summary for reviews and appeal hearings, thus limiting the amount of oral evidence then required and the fair notice given regarding the content of the RMO's evidence.

All Members responded very positively to the service user input to the training day, both from the parental and patient perspective.

All of these themes will be considered in the provision of training to Members in the future.

1 Statistics for the period October 2005 to September 2011

Learning disabilities tribunals

I am a solicitor and have been privileged to sit as a Legal Member of the Tribunal since 2005. I also work in private practice, mainly dealing with issues of children's welfare, and sit on the Parole Board for Scotland.

I have been asked to make a contribution to this year's Annual Report and to focus on the group of individuals who have a learning disability and come before tribunals. "Learning disability" is one of the three types of mental disorder specified in the 2003 Act, the other two being mental illness and personality disorder. I do not intend to be unduly legalistic as that would not be in the spirit of the 2003 Act, the first section of which sets out the principles underpinning the application of the legislation. The section emphasises the central role of the patient in the decision making about care and treatment, and the need for the patient's past and present wishes and feelings to be taken into account.

The 2003 Act does not define "learning disability", or discuss the particular needs of these individuals in the context of tribunals. However, a patient with a learning disability will have some difficulties with the Tribunal paperwork and proceedings. These factors need to be actively addressed before and during the tribunal in order to ensure the individual's fullest participation and to comply with the obligations the Act imposes.

The tribunal should think about whether the patient may need either additional help or help provided in a particular way, in order to participate as effectively as possible. For example:

- the room setting and seating arrangements;
- ask if the patient needs particular aids to help her/him to understand what is going on and to make her or his views and feelings known, for example, Boardmaker or "traffic-light" cards;
- ensure that the right people are there to support the patient and, conversely, that there are no unnecessary people in the hearing room whose presence might add to the strain on the patient;
- consciously think about the body language and vocabulary which is used and the speed of delivery;
- remember to ask the patient if s/he wants something repeated, needs a break, and to recap regularly; and
- be prepared to be flexible to meet the needs of the patient: it is her/his tribunal, not the panel's, the RMO's or the MHO's.

The patient should be addressed in the same courteous style as others and not casually referred to by a nickname or diminutive, unless this is the patient's preference. It is not appropriate to either address or refer to the patient as if s/he were less deserving of the usual courtesies because s/he has a learning disability. This sets her/him apart from the others in a manner which is expressly ruled out by the Act. It is my view that, if the patient feels unable to attend, the tribunal should offer to go and talk to her/him and so obtain her/his views. This action underlines that the patient is central to the process and not an individual about whom decisions are made because s/he has a learning disability, even if these decisions are purported to be in the patient's best interests.

The tribunal has a duty to consider the views of specified individuals, such as the named person and primary carer, who may know the patient very well. However, it is critical to remember when weighing the evidence that these people may have views different from and in conflict with those of the patient, even when they genuinely consider they are acting in the patient's best interests.

There may be concerns that the patient does not have capacity to represent herself/himself or instruct a solicitor, even with the appropriate support. In this case, the appointment of a

curator *ad litem* should be considered in order to ensure that the patient's rights are fully represented and that the critical issues about care and treatment are properly addressed.

The tribunal, when considering a matter concerning a patient with a learning disability, should remember its collective responsibility to ensure that the individual is enabled to participate as fully as possible; is listened to with respect and an open mind; that all the options are assessed; and that the maximum benefit is provided to that individual.

Every patient arrives at the tribunal with her or his individual story, wishes and needs. It is clear that, with the appropriate support and encouragement, many of those with a learning disability are able to participate in the hearing and, therefore, in the decisions about their treatment and care, as is their right. Others need more formal help, such as the appointment of a curator *ad litem*, to ensure their position is represented and the maximum benefit provided to them. My experience of convening tribunals for such individuals has been challenging and rewarding and I have no doubt it will continue to be so.

Joan M Morrison
Solicitor
Edinburgh

Key Developments in 2011/2012

Adolescent Hearings

As mentioned earlier in this Report, in March 2012 training took place on child and adolescent tribunals and a number of Tribunal Members participated in that training. For the 6 month period following the training, all Members sitting on a panel considering a case involving a child or adolescent will be specially selected from the list of people who attended the training to ensure a consistent approach when sitting on adolescent hearings.

Value Stream Mapping – Compulsory Treatment Order process

Operations staff were involved in this exercise to identify waste in the system and consider process improvements. This resulted in changes to our case management Information Communications Technology (ICT) system, including improved contacts data which ensures attendees can be electronically contacted more efficiently by staff as well as maximising secure email intimations.

More Efficient Use of Members' Time

The programme to move Members between venues on the same day continues to provide financial savings to the public purse. This initiative has helped support a doubled-up hearings rate for the year of 48%.

Forensic Training

A "New to Forensic Mental Health" training course was delivered which gave staff a good understanding of the work of the CORO team.

Adjournments/Interims

Rates continued to fall and the average rate for continued hearings was 28.68%. This is a significant improvement on previous years e.g. in financial year 2007/2008 the average rate for continuations was 39.45%.

Multi-functioning Staff

Administration staff are being trained to perform a number of tasks across operational areas to maximise efficiencies and provide a flexible workforce.

Hearings

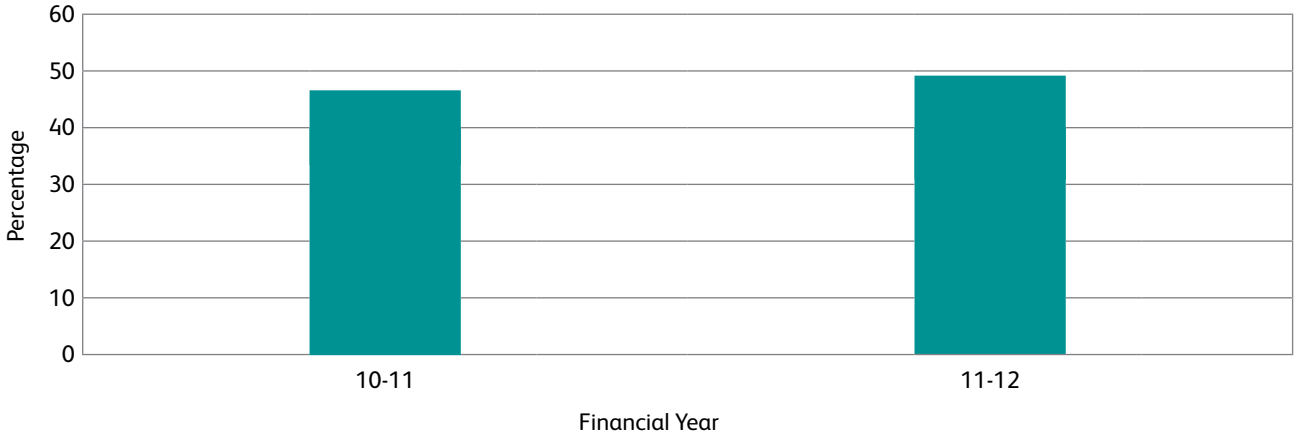
There has been an increase in the number of decisions being made at the first hearing which is to be welcomed, resulting in fewer patients and other parties requiring to attend more than one hearing before the final decision in a case is made.

Business Activity

The Tribunal has continued to develop the multiple hearing initiative which involves scheduling at least two hearings per panel per venue, whenever possible and appropriate. The overarching principal of this initiative is to reduce the number of hearing days required to be held by the Tribunal and to ensure better use of Members' time while maintaining the patient-centred approach which is of paramount importance to the Tribunal and its Administration.

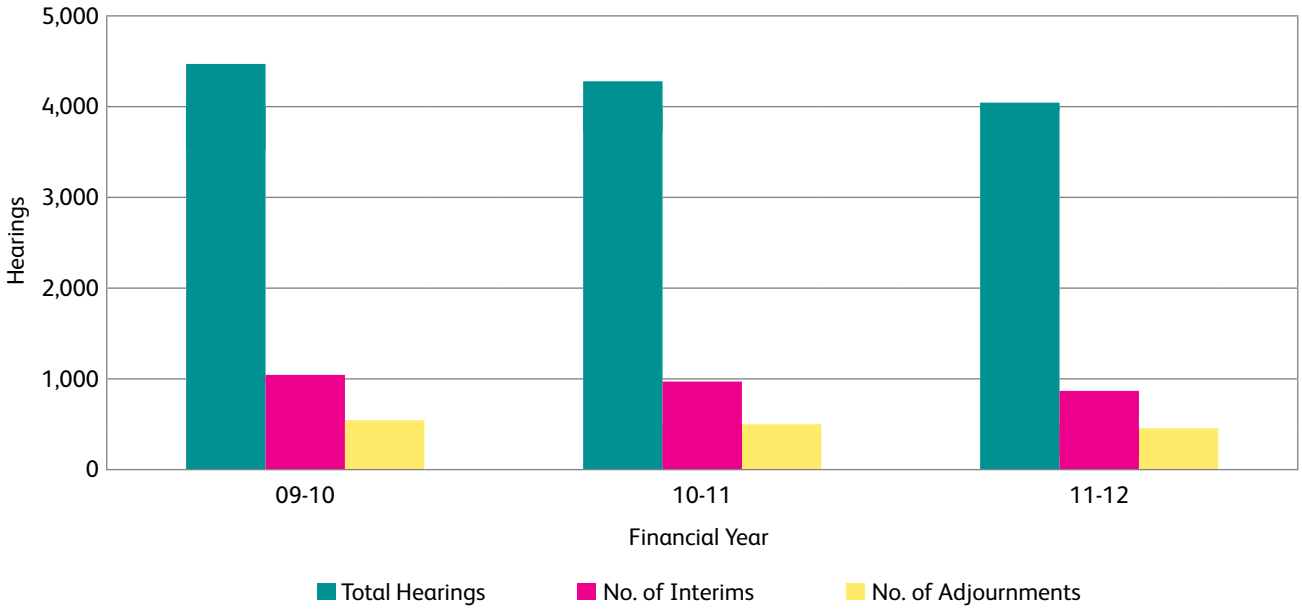
The sustained focus on developing a system which maximises the multiple hearing rate has been successful in 2011/2012, with monthly multiple rates regularly above 50% in the second half of the financial year. It is envisaged that the progress made this year, a near 3% rise in multiple rates, will continue in 2012/2013 with an expectation that the yearly return will be in excess of 50%.

Percentage Multiple Hearings

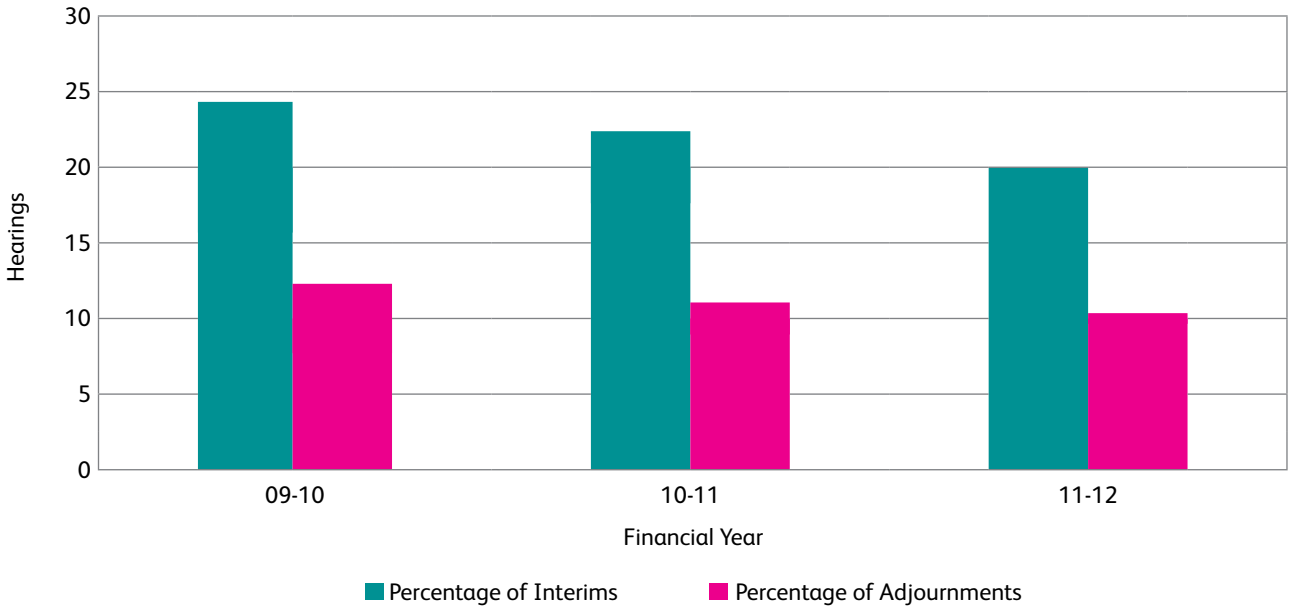


The number of hearings which are continued as a result of interim orders or adjournments has continued to reduce in 2011/2012. Streamlined procedures, initially identified in 2009/10, have continued to be refined as part of our commitment to the continual improvement of the service we provide. The improvement of this service, which includes a speedier process for the appointment of curators *ad litem*, a sustained focus on the relationship between the Tribunal and the Administration and a consistent high performance by those in the Administration team in terms of intimation to hearing attendees, has contributed towards the year-on-year drop identified in the graphs opposite. The percentage figure for all continued hearings (both interims and adjournments combined) for 2011/2012 is just over 30%. This compares favourably to the 2010/2011 total of nearly 33% and the 2009/2010 total of over 36%. The actual number of interim orders made in 2011/2012 has fallen by 23% from figures returned in 2009/2010. These statistics are encouraging and reaffirm that the Tribunal is moving in the right direction in terms of the service it is providing to those involved in proceedings before the Tribunal.

Interims and Adjournment against Total Hearings

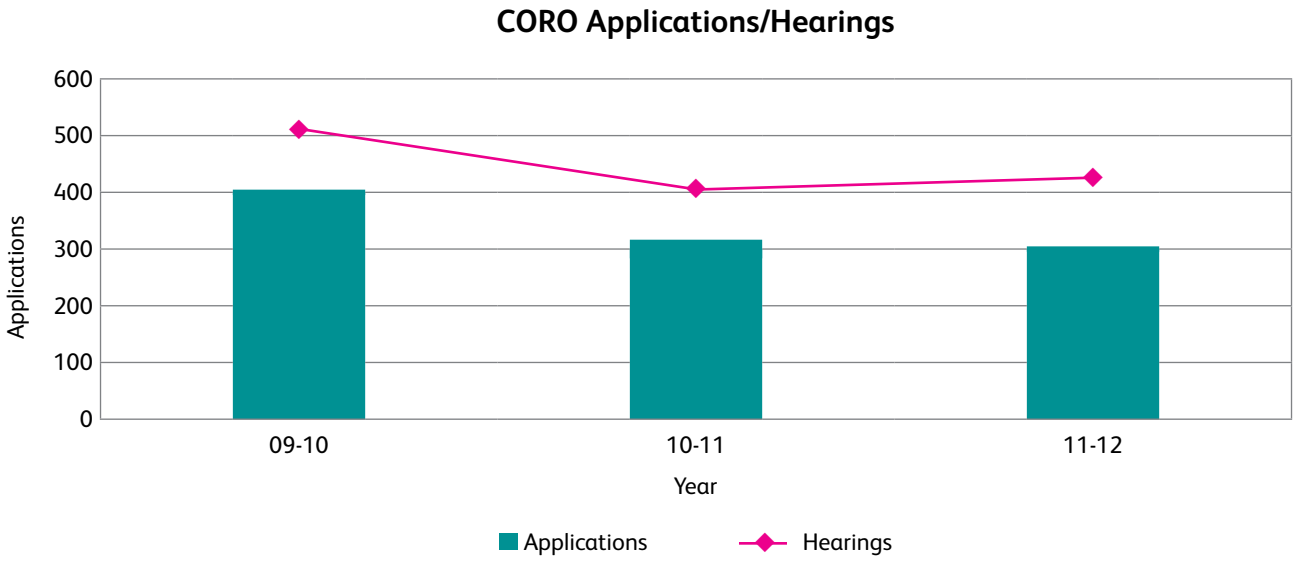


Interims and Adjournment as Percentage of Total Hearings

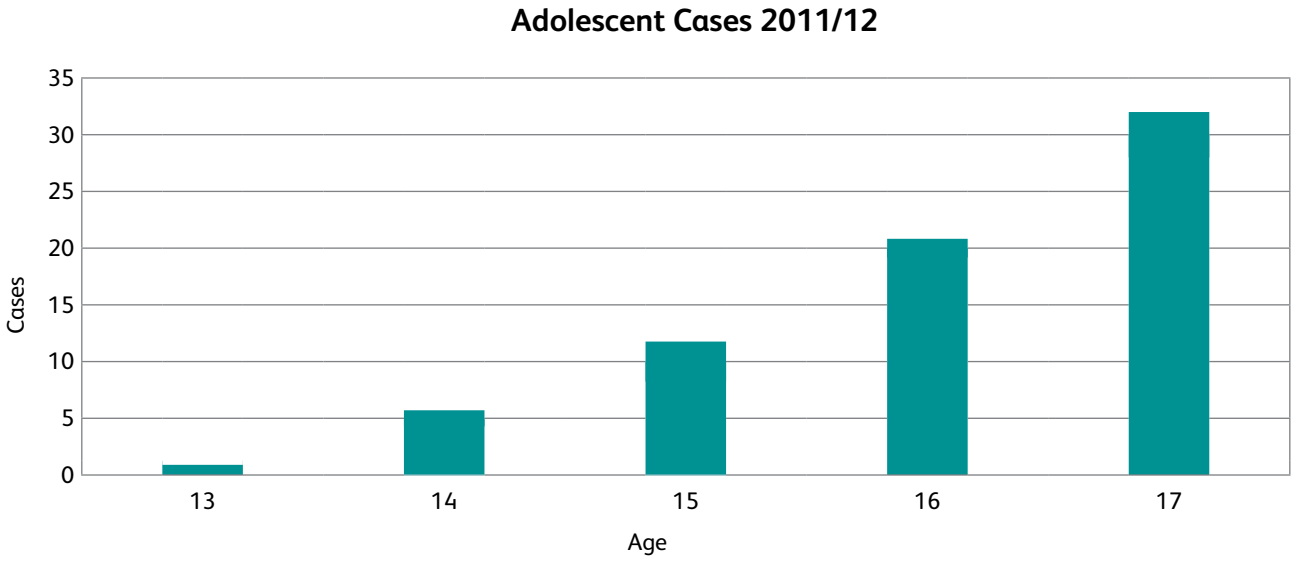


During the year, the number of CORO cases remained broadly in line with the level recorded in 2010/11. This may be a result of the 2-year review cycle now being well established after the first big tranche of these cases were processed when the provisions of the 2003 Act came into force.

Excessive security cases (cases where the patient seeks an order from the Tribunal declaring that s/he is being detained in conditions of excessive security in the State Hospital – section 264 of the 2003 Act) increased during 2011/2012 from seven to twenty-seven (N.B. not all excessive security cases involve restricted patients).



Due to an increase in the number of applications received by the Tribunal relating to patients under the age of 18, a need was identified to deliver child and adolescent training so that MHTS Members and staff had a better understanding of the needs and issues faced by patients detained under the 2003 Act who were under the age of 18.



Corporate Structure and Finances

Dr Joe Morrow was appointed President of the Tribunal in October 2008 and presides over the discharge of the Tribunal's functions. At the end of 2011/2012 the Tribunal had 334 Tribunal Members, also appointed by the Scottish Ministers. Members are responsible for making judicial decisions on cases and are split into three groups: legal Members, medical Members and general Members. Tribunal panels comprise one Member from each group, with the legal Member acting as convener of the panel. The Tribunal also draws on the support of a number of sheriffs who, along with the Tribunal's President, are required by the 2003 Act to convene panels hearing forensic cases.

By the end of March 2012 the Tribunal's Administration had a staff of 76 permanent civil servants under a Head of Operations, who in turn is responsible to the Chief Executive of the Scottish Tribunals Service. The Administration is responsible for carrying out the administrative and corporate functions of the Tribunal as delegated to it by the President.

The summary financial results for the Tribunal Administration for the year ended 31st March 2012 are shown in the Annex at the end of this report.

Public Services Reform (Scotland) Act 2010

The President of the Tribunal, in line with the heads of other public bodies, acknowledges his responsibilities under the Public Services Reform (Scotland) Act 2010 and, in accordance with statutory requirements, provides below:

- a statement of expenditure relating to public relations; overseas travel; hospitality and entertainment; external consultancy; and payments for goods and services which are greater than £25,000; and
- a statement of the steps taken during the financial year to (a) promote and increase sustainable growth and (b) to improve efficiency, effectiveness and economy in the exercise of its functions.

Expenditure relating to public relations, overseas travel, hospitality and entertainment and external consultancy by the Tribunal during 2011/2012

Public relations	Nil
Overseas travel	£1,451*
Hospitality and entertainment	Nil
External consultancy	Nil
Members and Members of staff of the Tribunal who received remuneration in excess of £150,000	Nil
Payments with a value in excess of £25,000	Nil

* In respect of the attendance of the President and Legal Secretary at the International Academy of Law & Mental Health conference in Berlin in July 2011.

Steps taken to:

(a) promote and increase sustainable growth; and

(b) improve efficiency, effectiveness and economy in the exercise of its functions.

During the year the Tribunal and Tribunal Administration have continued their efforts to reduce both expenditure and carbon footprint in a number of areas.

- Virtually all records are now maintained electronically.
- Efforts continue to encourage the use of secure electronic mail by Health Boards, Local Authorities and legal community, reducing costs and mail miles.
- The Administration continues to work with Health Boards to use their networks to access our systems meaning that Tribunal Clerks are able to work securely from those locations without the need to travel to a different location with resultant time, money and fuel savings.
- The Tribunal maintains maximum productivity by having Tribunal panels hear more than one case on the same day without compromising the rights of patients or other participants.

Annex

Financial Results

The Mental Health Tribunal for Scotland Administration

Operating Cost Statement

For The Year Ended 31st March 2012

2011 £000		2012 £000
5,667	**Tribunal Costs**	4,990
	Administrative Costs	
2,118	Staff	2,050
64	Depreciation	52
1,787	Other Costs	941
3,969		3,043
9,636	Net Operating Costs	8,033

Financial Performance

The costs in 2011/2012 show a distinct reduction (16%) over the 2010/2011 figures and this reduction is due, in the main, to various efficiency initiatives (e.g. multi-hearings in one day) undertaken throughout the year.

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