The Mental Health Tribunal for Scotland: the views and experiences of Patients, Named Persons, Practitioners and Mental Health Tribunal for Scotland members

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Declaration

Professor Jill Stavert is an Executive Team member of the Scottish Mental Health Law Review. Professor Michael Brown is a General Member of the Mental Health Tribunal for Scotland.

Glossary of Terms

Advance Statement	The Mental Health (Care and Treatment)(Scotland) Act 2003 (section 275) recognises that a patient may make a written statement whilst they have capacity expressing their wishes regarding how they do and do not want to be treated for their mental disorder. The statement becomes effective if the patient loses capacity.
Attorney	A person may grant powers to another person or persons to act in relation to health and welfare matters if the person loses capacity and/or in relation to financial and property powers either before or when the person loses capacity. Powers of Attorney are regulated by the Adults with Incapacity (Scotland) Act 2000.
Compulsory Treatment Order (CTO)	An order made under the Mental Health (Care and Treatment) (Scotland) Act 2003 for detention in hospital or compulsory community measures. It may be preceded by an interim Compulsory Treatment Order. The equivalent in the criminal justice system is a Compulsion Order or a Compulsion Order and Restriction Order (CORO).
Compulsion Order with Restriction Order (CORO)	A Compulsion Order (CO) may be made by a criminal court when an offender with a mental disorder is convicted of an offence (other than murder) that is punishable by imprisonment. The offender is not imprisoned but instead they must stay in hospital for mental health treatment.

	The court may also add a Restriction Order (RO) to the Compulsion Order where it considers that the person presents a risk of serious harm to others.
Curator ad litem	The Mental Health Tribunal for Scotland may appoint a *curator ad litem* to safeguard the interests of a patient who lacks capacity to nominate a named person or are unable to instruct a solicitor. The *curator ad litem* represents them at the tribunal hearing.
Full Findings and Reasons Report (FFR)	The written report recording the decision of the Mental Health Tribunal panel following a hearing.
Guardian	A person appointed by the Sheriff Court under the Adults with Incapacity (Scotland) Act 2000. The guardian has powers, as listed in the appointment, to take medical, welfare and/or financial decisions for an adult with incapacity.
Independent Advocate	In the context of Mental Health Tribunal for Scotland proceedings an independent advocate is someone who is unconnected to those providing services and assists the patient to understand information, make their choices and communicate these about care and treatment for mental disorder. The Mental Health (Care and Treatment)(Scotland) Act 2003 (section 259) places a duty on health boards and local authorities to provide anyone with mental disorder with access to independent advocacy.
Listed Initiator	A guardian, welfare attorney, primary carer or nearest relative of the patient

	may make an application or appeal to the Mental Health Tribunal (and receive information about proceedings) as a listed initiator under Section 257A of the Mental Health (Care and Treatment) (Scotland) Act 2003 where the patient is 16 or over, does not have a named person and lacks the capacity to make an application or appeal to the tribunal.
Mental disorder	Is defined by section 328 of the Mental Health (Care and Treatment) (Scotland) Act 200. It currently includes mental illness, learning disability and personality disorder.
Mental Health Officer (MHO)	A specially trained and experienced social worker with a role in legal proceedings under the Mental Health (Care and Treatment) (Scotland) Act 2003.
Named Person	A person nominated by the patient who looks after the patient's interests when they are subject to compulsory measures. A named person has similar rights to the patient.
Short Term Detention Certificate (STDC)	This allows detention in hospital for up to 28 days (section 44 Mental Health (Care and Treatment)(Scotland) Act 2003). It must be authorised by an 'approved medical practitioner' which is someone who is a medical practitioner who has been approved as having special experience in the diagnosis and treatment of mental disorder.
Recorded Matters	Treatment, care or services which the Mental Health Tribunal considers

	essential to an individual’s care (for example, medical treatment, community care services, children’s services, psychological support and addiction services) which are specified in a CTO when made
Responsible Medical Officer (RMO)	The psychiatrist responsible for the care of a person subject to a compulsory order under the Mental Health (Care and Treatment) (Scotland) Act 2003.

Executive Summary

The background to this study

Mental disorder impacts on those living with it and their family members, unpaid and paid carers and the professionals and bodies responsible for their assessment, care, treatment and support. In Scotland, it has been estimated that one in four people will experience mental health challenges each year (Scottish Government, 2019a). This incidence has increased and is likely to continue to do so in the foreseeable future due to the coronavirus pandemic (Pierce et al., 2021).

Importantly, those living with mental disorder may occasionally require care and treatment to be authorised under the law and delivered non-consensually. However, whether psychiatric care and treatment is voluntary or involuntary, international human rights standards, notably the European Convention on Human Rights and Convention on the Rights of Persons with Disabilities (CRPD), require that safeguards are in place to protect individuals' rights against arbitrary and unnecessary restrictions of their autonomy, as well as rights to supported decision-making, to dignity, to the right to the highest attainable standard of physical and mental health and to live independently and to alternatives to compulsory psychiatric detention and treatment.

When enacted the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) was seen as world-leading in terms of its person-centred and human rights-based approach to the care and treatment of persons with mental disorder. This approach was reinforced by various principles, often referred to as the 'Millan Principles', which are non-discrimination, equality, respect for diversity, reciprocity, informal care, participation, respect for carers, the least restrictive alternative, benefit and child welfare. The Act also established the Mental Health Tribunal for Scotland (MHTS) as the forum to authorise and review compulsory psychiatric measures and safeguard the rights of patients in this context, particularly those relating to autonomy, which require consideration of the appropriateness of detention and treatment of a person and proportionality of any restrictions. The MHTS started its work in 2005 and there is consequently now a substantial amount of experience of its processes and decision-making to assess how well it is operating in safeguarding patients' rights when facing or subject to compulsory measures.

The significance of this study

This study is significant for several reasons, all of which relate to the need to ensure respect for the rights of persons with mental disorder. Psychiatric compulsion rates vary across the world (Sheridan Rains et al., 2019), and are rising in Scotland (Mental Welfare Commission for Scotland, 2021). There is international concern about how effectively mental health tribunals protect patients' rights (UN Human

Rights Council, 2017; Macgregor et al., 2019). Scotland will increasingly be required to give effect to the CRPD (which the UK ratified in 2009 following the enactment of the Mental Health Act) and this requires a much more proactive, holistic and non-discriminatory approach to realising the rights of persons with mental disorder.
The MHTS is also to shortly move from being a free-standing tribunal to being a chamber within the Scottish tribunals system and there are accompanying concerns about the potential dilution of its specialist role. Additionally, and importantly, the Mental Health Act is currently the subject of an independent review which will report in September 2022 (the Scott Review).

The study and the remit

This study, funded by the Nuffield Foundation, which ran from October 2017 until April 2022, is the first of its type in terms of bringing together in one study a range of views and experiences of MHTS processes and decision-making from a purposive sample of stakeholders including MHTS panel members, health and social care professionals, patients and named persons. Adopting mixed qualitative and quantitative methods, including conducting interviews with patients and named persons (described in the Glossary of Terms) and focus groups involving MHTS panel members and health and social care professionals (including clinicians, Mental Health Officers, solicitors and independent advocates), it examined perceptions of how the extent to which the human rights informed Millan Principles are given effect by the MHTS including aspects of good practice and areas where improvements should be made.

The study's function was to consider the experiences of the MHTS under existing legislation and its preparedness for potential future changes. Whilst noting the significant international debate on the efficacy of compulsory psychiatric treatment (UN Committee on the Rights of Persons with Disabilities, 2014, 2015), it did not therefore evaluate such experiences and roles against this, nor did it seek to determine the legality of individual applications and outcomes as there is a clearly defined appeal process for this.

Findings and conclusions

We encountered considerable caring goodwill on the part of MHTS panel members and health and social care professional participants and a determination to give effect to the Mental Health Act principles and rights of patients. This was accompanied by reflection on what worked well and where improvement is perceived necessary. Patient and named person participants were equally reflective although generally more critical of the MHTS processes. There were several areas of agreement between all participant groups as well as certain areas where the experience of patients and MHTS panel members was not shared. Notable areas of concern raised mainly by patient and named person participants, and by some

MHTS panel members and health and social care professional participants, related to perceptions surrounding effective patient and named person participation and clinical-patient power imbalance at MHTS hearings. The need for greater MHTS awareness around equality and diversity and CRPD requirements was also identified.

We also heard of the frustrations of MHTS panel members caused by wider resourcing issues within the health and social care system which sometimes weakened their ability to give full effect to these principles. Data obtained from health and social care professionals, patients and named persons certainly identified areas of good practice relating to MHTS processes and decision-making. However, concerns were raised (despite the best efforts of MHTS panel members) over particular aspects of this, namely relating to patient participation (and support for such participation), and perceptions of power and influence of clinicians, both of which appeared to significantly influence perceptions of fairness. Other areas of particular concern related to the role and support of named persons and carers and representation. The study gained the views of only a sample of persons with experience of the MHTS processes and decision-making. However, these views should not be dismissed and appear to be more widely supported by Scott Review evidence and other studies. Nor do the identified concerns appear to be confined entirely to the MHTS as they have also been noted in other jurisdictions (Macgregor et al., 2019).

We recognise that not all the issues raised by patients, named persons and health and social care professionals can be addressed by the MHTS. It is important to differentiate where this is the immediate responsibility of the MHTS and where it is not and where it is in fact the responsibility of the Scottish Government, clinicians, solicitors, NHS Boards and local authorities, or requires legislative change. These issues are reflected in our evidence informed recommendations for action.

Recommendations for action

Recommendations for action within the remit of MHTS

The MHTS should:

1. Review the CRPD requirements of non-discrimination, alternatives to non-consensual psychiatric care and treatment and supported decision-making which can enhance the implementation of the Millan Principles and reflect this in its decision-making.
2. Identify where imbalances of power, particularly in relation to the clinical/medical domain, may be perceived by patients to occur and actively seek to address this.
3. Identify obstacles to patient participation in their hearings and put in place measures to address them.

4. Ensure that named persons have the opportunity to access independent advocacy and legal representation before, during and after the tribunal hearing.
5. Review the processes and practices to ensure that named persons are provided opportunities to provide their views either in person or in writing at a hearing.
6. Review the processes and practices to ensure that the views of patient and their named person are fully and accurately presented in Full Findings and Reasons reports.
7. Review the processes and practices to ensure that patients and their named person have access to information regarding the hearing and the order being requested and the potential outcomes.
8. Review the processes and practices to enable the effective scrutiny of care plan proposals and the service delivered to promote reciprocity for patients.
9. Consider the different characteristics highlighted on section 1(3)(h) of the Mental Health Act[1] and effect reasonable adjustments and accommodations in order to ensure equality of rights enjoyment in MHTS processes and decision-making.
10. Establish further training and development opportunities for MHTS panel members in to address the developments required in processes and practices that pro-actively involve patients, their families and named persons in this.

Recommendations for action outside the remit of the MHTS

To be included in the Scott Review final report recommendations and be reflected by the Scottish Government in subsequent legislative and policy reforms:

11. The reinforcement of the CRPD requirements outlined above in legislation.
12. The review of the status and position of recorded matters by placing a statutory enforceable duty on NHS Boards and local authorities for compliance.
13. Establish a statutory mechanism to raise, monitor and respond to general issues other than recorded matters arising during MHTS processes and hearings.
14. Evaluation of existing and alternative measures for supporting participation in the MHTS processes by patients and named persons, including the role of advance statements.
15. Review the role of named persons and the availability of legal representation.
16. Review the role and efficacy of *curators ad litem*.
17. A statutory duty on clinical teams to consider alternatives to compulsory psychiatric care and treatment.

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[1] In other words, 'the patient's abilities, background and characteristics, including, without prejudice to that generality, the patient's age, sex, sexual orientation, religious persuasion, racial origin, cultural and linguistic background and membership of any ethnic group.'

The Scottish Government should ensure:

18. Adequate resourcing of community-based services and support for persons with mental disorder.
19. The development of easily accessible independent resources and information regarding the Mental Health Act and the MHTS process for patients, named persons, and families.
20. Increased resourcing for independent advocacy.
21. The commissioning of research that explores the experiences of children and young persons and persons living with dementia of MHTS processes and decision-making.

The Scottish Government should require and the Law Society of Scotland should ensure:

22. Training for solicitors representing patients and named persons on common mental health conditions and care, support and treatment in hospital and communities and related ECHR and CRPD requirements.

Chapter One: Introduction

1.1. The background to the study

The overall objective of this Nuffield Foundation funded study, which ran from October 2017 until April 2022, was to evaluate stakeholder perceptions of human rights compliance of the Mental Health Tribunal for Scotland in its decisions and processes relating to the non-consensual care and treatment of persons with “mental disorder” under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act), Scotland’s current mental health legislation.

“Mental Disorder” is defined in section 328 of the Mental Health Act as including:

> ‘*(a) mental illness;*
> *(b) personality disorder; or*
> *(c) learning disability,*
> *however caused or manifested; and cognate expressions shall be construed accordingly.*
>
> *(2) A person is not mentally disordered by reason only of any of the following—*
> *(a) sexual orientation;*
> *(b) sexual deviance*
> *(c) transsexualism;*
> *(d) transvestism;*
> *(e) dependence on, or use of, alcohol or drugs;*
> *(f) behaviour that causes, or is likely to cause, harassment, alarm or distress to any other person;*
> *(g)acting as no prudent person would act.*’

We recognise that the term “mental disorder” is now considered by many to be inappropriate and stigmatising. Indeed, the efficacy of its continued use was considered by the Millan Committee (1999-2000) (Scottish Executive, 2001) whose recommendations led to the enactment of the Mental Health Act. It is also currently being considered by the Scottish Mental Health Law Review (Scott Review). However, for the sake of clarity, because the Mental Health Act uses the term “mental disorder” we will refer to it in this report whilst at the same time fully acknowledging its shortcomings. Similarly, we are aware that using the term “patient” when referring to a person with lived experience of mental disorder may unnecessarily pathologise that person’s situation. However, again for the sake of clarity, it is used in this report because this is a term used by the Mental Health Act.

Mental disorder impacts on those living with it and their family members, unpaid and paid carers and the professionals and bodies responsible for their assessment, care, treatment and support. In Scotland, it has been estimated that one in four people will experience mental health challenges each year (Scottish Government, 2019a) and the incidence of mental ill-health has increased and is likely to continue to do so in the foreseeable future as a result of the coronavirus pandemic (Pierce et al., 2021).

The prevalence of mental disorder in our society is thus significant and importantly, irrespective of numbers, anyone living with it may require support. Sometimes such support takes the form of psychiatric care and treatment and occasionally this may be delivered compulsorily with the law requiring that a person is detained and treated without their consent.

Whether psychiatric care and treatment is voluntary or involuntary it must always be provided in a way that respects the dignity and autonomy of the individual and is non-discriminatory. Moreover, requiring that a person is detained and treated against their will must never be taken lightly. International human rights standards require safeguards to protect individuals against arbitrary and unnecessary restrictions and this is brought into even sharper relief given that level of psychiatric compulsion appears to be increasing in several countries across the world (Sheridan Rains et al., 2019) including Scotland (Mental Welfare Commission for Scotland, 2021).

1.2. Scotland’s mental health legislation: the Millan Principles

The Mental Health Act permits, subject to certain criteria, and regulates the detention and non-consensual care and treatment of persons with “mental disorder”. It was enacted by the Scottish Parliament as a result of recommendations made in the 2001 Millan Committee report *New Directions: Review of the Mental Health (Scotland) Act 1984* (the Millan Report) (Scottish Executive, 2001), following an independent review of mental health legislation at the time. The report considered ways to improve the addressing of the needs of persons with significant mental disorder. Importantly, in recognition that compulsory care of this nature impacts on an individual's dignity and autonomy, the Millan Report emphasised the need for any new legislation to reflect those rights identified in the European Convention on Human Rights (ECHR) and 'developing norms of human rights law'[2] to ensure that the autonomy of persons with mental disorder is preserved as much as possible and that appropriate care and treatment is provided. It therefore recommended (Scottish Executive, 2011)[3] that certain patient-centred and human rights-based principles,

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[2] Chapter 1, paras 25 and 26.

[3] Recommendation 3.3.

known as the “Millan Principles”, underpin the operation of mental health legislation which are:

> ‘1. *Non discrimination*
> *People with mental disorder should whenever possible retain the same rights and entitlements as those with other health needs.*
>
> *2. Equality*
> *All powers under the Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, race, colour, language, religion or national or ethnic or social origin.*
>
> *3. Respect for diversity*
> *Service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background.*
>
> *4. Reciprocity*
> *Where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide appropriate services, including ongoing care following discharge from compulsion.*
>
> *5. Informal care*
> *Wherever possible care, treatment and support should be provided to people with mental disorder without recourse to compulsion.*
>
> *6. Participation*
> *Service users should be fully involved, to the extent permitted by their individual capacity, in all aspects of their assessment, care, treatment and support. Account should be taken of their past and present wishes, so far as they can be ascertained. Service users should be provided with all the information necessary to enable them to participate fully. All such information should be provided in a way which renders it most likely to be understood.*
>
> *7. Respect for carers*
> *Those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.*
>
> *8. Least restrictive alternative*
> *Service users should be provided with any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner and*

environment compatible with the delivery of safe and effective care, taking account where appropriate of the safety of others.

9. Benefit

Any intervention under the Act should be likely to produce for the service user a benefit which cannot reasonably be achieved other than by the intervention.

10. Child welfare

The welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act.'

These are largely reflected in sections 1 and 2 of the Mental Health Act which are set out in Appendix A and will be discussed in more detail in Chapters Three and Four. At the time of enactment, the Mental Health Act was internationally regarded as being a world leader in terms of this person-centred and human rights-based approach to care and treatment for mental disorder (Mackay, 2012; Griesbach & Gordon, 2013). Over time, however, there appears to have been an inevitable slippage as human rights standards have further developed and evidence on the implementation of the Act has been collected (McKay & Stavert, 2017) thus leading to the current review.

1.3. The Mental Health Tribunal for Scotland

The Millan Report also considered the most appropriate forum to hear and decide matters relating to the compulsory care and treatment of patients with mental disorder and recommended the establishment of an independent specialist mental health tribunal. The Mental Health Act subsequently provided for the creation of the Mental Health Tribunal for Scotland (MHTS) which became operational on 5 October 2005. This replaced the Sheriff Court which had heard applications for compulsory psychiatric care and treatment under the preceding Mental Health (Scotland) Act 1984. Over the years, the MHTS has developed the panel members' specialist mental health law and procedure knowledge[4], including that relating to children and young persons, alongside a culture of therapeutic jurisprudence (Morrow, 2011).

MHTS panels for hearings include three members, a "Legal Member" (with legal qualifications, training and experience), a "Medical Member" (with qualifications, training and experience in medicine and the diagnosis and treatment of mental disorder) and a "General Member" (with qualifications, training, skills and experience in caring or service provision for persons with mental disorder)[5]. The Legal Member is also the panel Convenor. The MHTS's primary role is to consider and determine applications for Compulsory Treatment Orders (CTOs) and to hear appeals against

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[4] *Scottish Ministers v MHTS (JK)* 2009 SC 398.

[5] Schedule 2, Mental Health Act.

compulsory measures made under the Mental Health Act as well as conducting periodic reviews of compulsory measures[6]. The MHTS's processes and decisions therefore play an integral role in ensuring compliance with and respect for the rights of patients with mental disorder facing, or subject to, compulsory measures under the Act.

1.4. Human rights and mental disorder

For the UK, and Scotland as a devolved region of the UK, the most relevant human rights treaties relating to the care and treatment of persons with mental disorder are the ECHR and Convention on the Rights of Persons with Disabilities (CRPD).

ECHR rights that are particularly relevant to psychiatric care and treatment are the rights to liberty (Article 5), respect for private and family life (autonomy) (Article 8) and fair hearings (Article 6), and the prohibition of torture or inhuman or degrading treatment or punishment (Article 3), which must be enjoyed without discrimination on the basis of mental disorder (Article 14 ECHR). These rights define the limits of non-consensual interventions, and their focus is on this although the case law of the European Court of Human Rights emphasises the need to respect the autonomy of persons with mental disorder[7]. The CRPD includes these rights[8] but goes further than this in that the treaty identifies wider rights that underpin support for persons with mental disorder and integration in society such as support for the exercise of legal capacity (often referred to as 'supported decision-making') (Article 12(3)) and reasonable accommodation (Article 5(3)), independent living (Article 19) and the highest attainable standard of physical and mental health (Article 25). Importantly, the CRPD is clear that a diagnosis of mental disorder, or any impairment related to this, must never justify a restriction of the human rights of a person with mental disorder (Articles 1 and 5) (UN Committee on the Rights of Persons with Disabilities, 2018). A person with a disability must first be supported, where necessary, to enjoy their rights on the same basis as all others. Only after this has occurred should such rights be limited and then on the same basis for everyone. This reflects the social and human rights model of disability promoted by the CRPD which regards disability not in terms of a person's diagnosis itself but rather as the result of state and societal barriers to that person's rights enjoyment and integration in society. It requires that the state proactively removes such barriers and represents a 'paradigm shift' in approaches to the rights of persons with disabilities including mental disorder.

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[6] For a list of applications that can be made to the MHTS, see Appendix B. The MHTS can only make civil orders but can review orders made by courts in the criminal justice system relating to mentally disordered offenders (Part

[7] See, for example, the recent ruling in *N v Romania (No 2)* (Application no 38048/18) Judgment 18 November 2021.

[8] Articles 12 (equal recognition before the law), 13 (access to justice), 14 (liberty), 15 (freedom from torture or inhuman or degrading treatment or punishment) and 17 (protection of physical and mental integrity).

1.5. Scotland’s human rights framework

As a state party to both the ECHR and CRPD the UK is placed under an international law obligation to give effect to the rights identified in these treaties via its national laws, policies and practices. This duty extends to Scottish devolved legislation which includes mental health legislation in Scotland.

The UK-wide Human Rights Act 1998[9] and the Scotland Act 1998[10] require Scottish Parliament legislation, which includes mental health legislation, and the actions and decisions of Scotland’s public authorities which includes the MHTS, to be compatible with ECHR rights. At the time of the Millan Report and enactment of the Mental Health Act the focus was on the ECHR as the UK has only ratified this treaty. However, the UK subsequently ratified the CRPD in 2009.

Currently, there are no rights to apply to the courts and tribunals in Scotland to enforce CRPD rights although proposed devolved legislation and ministerial action in Scotland may be prevented if it is incompatible with the treaty[11]. The significance of this treaty in Scotland cannot, however, be ignored as will be explained later.

1.6. Mental health tribunals as guardians of rights

Mental health tribunals are internationally regarded as impartial safeguarders of the rights of persons experiencing mental ill-health and as more participatory than courts (Carney & Beaupert, 2008; Ng et al., 2016). That being said, concerns have been voiced over the ability of such tribunals to fully protect the rights of persons experiencing mental ill-health and that they merely legitimise psychiatric coercion and cause even greater isolation of persons within mental health systems from access to justice (MacGregor et al., 2019; UN Committee on the Rights of Persons with Disabilities, 2014, 2015; UN Human Rights Council, 2017). The MHTS now receives over 5,000 applications annually concerning a wide range of persons across Scotland with mental disorder (MHTS, 2020/21). A considerable amount of data, information and personal experience has consequently become available allowing for a comprehensive evaluation of how effectively it is perceived by patients, their named persons, professionals and MHTS panel members as fulfilling its role in safeguarding patients’ rights. This study therefore sought to conduct such an evaluation with the following aims and objectives and research questions.

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[9] Sections, 2, 3 and 6 Human Rights Act 1998.

[10] Sections 29(2)(d) and 57(2) Scotland Act 1998.

[11] Sections 35(1)(a) and 58(1) Scotland Act 1998.

1.7. Aims and objectives of the research study

The study had three broad aims:

1. To investigate and analyse the profile of the referrals made to, and the scope of the work undertaken by, the MHTS.
2. To investigate the views and experiences of patients, their named person, health and social care practitioners and MHTS members of the MHTS processes and decisions; and
3. To investigate the extent to which the MHTS gives effect to the Millan Principles and international human rights standards.

To this end, the study questions were:

1. What is the profile and scope of the applications and work undertaken by the MHTS?
2. What are the views and experiences of the users of MHTS and the MHTS members?
3. To what extent does the MHTS currently give effect to the Millan Principles and existing and evolving international human rights standards?

1.8. The importance of this study

An important indicator of the degree to which human rights are being fully realised is how they are experienced by those whose rights they seek to protect and enable. The significance of this study is that it is the first of its kind to undertake comprehensive and focused independent research of the extent to which a mental health tribunal's processes and decisions meet human rights standards from a multi-stakeholder perspective.

Prior to the study's commencement, research on the functioning of the MHTS has been very limited, not fully exploring the views of all stakeholders specifically in relation to the MHTS (Ridley et al., 2010; Ridley & Hunter, 2013). Moreover, international research on tribunals has been limited (MacGregor et al., 2019). As was previously the case in Scotland, such research has also tended to consider specific stakeholder groups and not be explicitly human rights focused. The current study therefore seeks to address these issues.

The importance of this study is on several levels. Firstly, the findings provide an indication of how well the MHTS is perceived to be currently operating as a protector of patients' rights and where there might be room for improvement in its processes. Secondly, it provides an indication of how well placed it is as a guardian of the rights of persons with mental disorder going forward in light of various noteworthy developments in Scotland. These developments can be summarised as follows:

1.8.1 The Scott Review

On the 19th March 2019, the Scottish Government Minister for Mental Health announced a comprehensive independent review of Scotland's mental health legislative framework chaired by John Scott QC. The review's Terms of Reference state that its principal aim:

'…is to improve the rights and protections of persons who may be subject to the existing provisions of mental health, incapacity or adult support and protection legislation as a consequence of having a mental disorder, and remove barriers to those caring for their health and welfare.
'

and that 'It will do so by:

- *reviewing the developments in mental health law and practice on compulsory detention and care and treatment since the Mental Health (Care and Treatment) (Scotland) Act 2003 came into force'.*

- *making recommendations that gives effect to the rights, will and preferences of the individual by ensuring that mental health, incapacity and adult support and protection legislation reflects people's social, economic and cultural rights including [UN]CRPD and ECHR requirements; and*

- *considering the need for the convergence of incapacity, mental health and adult support and protection legislation.'* (Scott Review, 2021)

This will involve consideration of, amongst other things:
'how equal and non-discriminatory enjoyment of rights can be achieved'

and

'*maximising decision-making autonomy whenever interventions are being considered under all three pieces of legislation, including a focus on alternatives to coercion, supported decision-making and the roles of named persons, guardians, nearest relatives, listed initiators, mental health officers, council officers, independent advocates and others'*

and

'patients' experiences of care and treatment whilst subject to compulsion' (Scott Review, 2021).

Experiences of the decisions and process of the MHTS and their human rights compliance are therefore highly relevant to the Review and its ultimate recommendations.

1.8.2 Developing and emerging human rights norms: national imperatives and international reach

As previously stated, the Millan Principles were largely informed by ECHR rights with a more restricted focus in the context of care and treatment of persons with mental disorder. Whilst the CRPD does not carry the same legal weight as ECHR rights in Scotland at the moment, its prominence in recent reviews of mental health and capacity law most notably, as already mentioned in the Scott Review[12], is clear and the review's recommendations for legislative change will have both ECHR and CRPD firmly in mind. The need for this is, importantly, reinforced by the fact that the Scottish Government has indicated that it will act on the recommendation of its National Taskforce on Human Rights Leadership (Scottish Government, 2021a) to incorporate the CRPD, amongst other international human rights treaties, into national law.

The CRPD requires that the state both respects and actively supports the autonomy of persons with mental disorder and does not deny this support and the enjoyment of rights based on disability or related impairment. The MHTS, as a public authority, will need to reflect this. At present, or immediately, this requires that the MHTS reflects this in the context of its functions under the Mental Health Act. The more restricted approach of the ECHR sets minimum standards that the state must achieve but which can be enhanced by interpreting ECHR rights through a CRPD lens. Such an approach has been reinforced by the World Health Organisation (World Health Organisation, 2021).

The Mental Health Act, as already stated, upon enactment was heralded as being world-leading in its human rights and person-based approach to compulsory psychiatric care and treatment. There is accordingly a considerable amount of international interest in the operation and development of this legislation, not least in light of concerns raised at United Nations and World Health Organisation over the use of mental health law and the role of tribunals.

1.8.3 Change in MHTS structure and remit

The MHTS's existing structure and remit may change. As a result of MHTS structural reform[13] and the Scott Review:

1. The MHTS will be absorbed as a chamber within the unified Scottish devolved tribunals structure in 2022. After this, there is the potential that Scottish

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[12] The Scott Review has absorbed the previous work the Independent Review on Learning Disabilities and Autism in the Mental Health into its own work (see *Independent Review of Learning Disability and Autism in the Mental Health Act: Final Report*, December 2019).

[13] Tribunals (Scotland) Act 2014, sections 1, 2, 20, 35 and Schedule 1, Part 1.

Ministers may seek to further extend the jurisdiction, thereby raising the possibility that mental health law specialism is diluted.

2. In consequence of the Scott Review recommendations, there is a possibility that the MHTS's jurisdiction may be extended to also include those persons who currently fall within the remit of incapacity and possibly even adult protection law. This will significantly increase the MHTS's workload.

Each of these challenges has the potential to impact on the protection of the rights of persons with mental disorder and thus the MHTS's function to safeguard these.

1.9 Clarifying the scope of the study

Before proceeding further, it was necessary to clearly set out the scope of the study.

Firstly, it is pertinent to note the ongoing international debate on the efficacy of compulsory psychiatric treatment and related calls for the abolition of laws allowing for non-consensual care and treatment justified based on psycho-social, cognitive or intellectual disability or associated cognitive impairments (UN Committee on the Rights of Persons with Disabilities, 2014, 2015). These are issues currently being considered by persons with lived experience of mental disorder, governments, legislative bodies, professionals, monitoring bodies and academics across the world and including in Scotland. This clearly raises challenges for the Mental Health Act which is being considered by the Scott Review, and the Rome review preceding it. The study does not, however, seek to enter or critique this debate. The function of this study is to consider the role of the MHTS under existing legislation, accepting that this is the law currently in place in Scotland, and its preparedness for potential future changes.

Secondly, the focus has been on a range of stakeholder views and perceptions of the decisions and processes of the MHTS only. The role of the MHTS in authorising involuntary care and treatment and protecting the rights of patients is a significant one. However, it is only part of the process of mental health care and treatment. MHTS is not responsible for mental health service delivery in Scotland which rests with health and social care services. Additionally, this study does not seek to determine the legality of individual cases involving the MHTS as there is a clearly defined appeal process for this[14].

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[14] Part 22 (sections 320-324) Mental Health (Care and Treatment) (Scotland) Act 2003.

Chapter Two: Methodology

2.1. Study design

Using both qualitative and quantitative methods, the study was conducted over four distinct and interrelated phases. Mixed methods research approaches are known for the provision of detailed breadth and depth while enhancing trustworthiness and reliability of study findings (Hesse-Bieber, 2010; Watkins and Gioia, 2015). The study design therefore aligned with the ‘complementarity function’ of mixed methods research in which each method is used to answer related questions for an evaluative or elaborative purpose (Palinkas et al., 2011). Specifically, quantitative analysis was used to answer the first research question, and qualitative approaches were necessary to answer the subsequent two research questions as part of the comprehensive evaluation of the MHTS.

2.2. Phase One: Systematic literature review and advisory groups

In order to provide a wider, global, context for the study its first stage involved a systematic literature review (MacGregor et al., 2019) of all relevant literature published in the research databases, including MEDLINE, CINAHL, PsychINFO, ASSIA, Web of Science, LexisNexis and Westlaw, between 2000 and 2018. Headings and keywords were used to identify national and international research on mental health tribunals. All study designs were included, provided they contained relevant keywords or indexing terms, were published in English, had been peer-reviewed, and addressed at least one of the research questions. Articles that focused upon compulsory treatment more broadly that do not include views or experiences of the tribunal were excluded. Thirty-two studies were included, and eight key themes were identified: information and understanding, patient representation, the power of the medical domain, feelings of powerlessness, perceptions of fairness, risk, and impact on relationships.

A Scottish Advisory Board comprising representatives from stakeholder organisations and user and carer groups was established. It met periodically with the purpose of guiding and informing the study and ensuring that the patient and carer voice and expertise were included. To ensure and enhance the relevance of the study internationally an International Advisory Group with academic, practitioner and lived experience representation was also established so that members of this could be consulted, if needed, to provide international and other jurisdiction context.

2.3. Phase Two: MHTS Data Analysis

Phase Two involved the analysis of routinely collected data from the MHTS. This was to inform the recruitment process in Phase Three of the study. Anonymised data was obtained from all cases recorded by the MHTS since its inception in 2005 but only data from applications that took place over the past five years was selected when approaching potential patient participants. The data included: age, gender, ethnicity, health board and local authority areas, mental disorder category - mental illness, learning disability, personality disorder - and type of order, including short-term detention certificate appeals, compulsory treatment order applications, extensions and variations, and compulsion and restriction orders and variations, extensions, and appeals.

This quantitative data was analysed using SPSS 23. The data provided an overview of the MHTS's activities, referrals to the tribunal, and hearing outcome descriptions. Percentages were used to understand patterns relating to age, gender, ethnicity, mental disorder category, NHS Board and local authority area, the proportion of orders that were hospital or community based, and the use of named persons, recorded matters, and advance statements. The data analysis was affected by several limitations associated with the available data. The MHTS case management system was set up for the administration of the MHTS and not for the purposes of research and this resulted in several issues in analysing the data. Firstly, the quality of the MHTS data was variable. The data was intact for information relating to named persons, advance statements, curators, recorded matters, and tribunal outcomes, however, this was weaker in relation to demographic information. This was limited in relation to ethnicity and the category of mental disorder, where two thirds and one third respectively were missing from the data set. Secondly, each application is recorded as a separate case.

Due to the anonymisation of data, it was not possible to link cases to individuals although this would have allowed a better understanding of individual journeys through the tribunal system, including repeat referrals. Furthermore, the intention was to examine MHTS outcomes in relation to the percentage of applications for compulsion that were either granted, refused, or not applicable. For example, where a tribunal did not go ahead. However, the way in which the MHTS records the case outcomes did not permit this. The MHTS uses a total of 15 different outcome categories. Two of these are 'revoked' and 'revocation' and these are used interchangeably when either the tribunal or the applicant revokes the order. This means that the case may not have gone to a tribunal. As a result, it was not possible to ascertain the total percentage of applications that were granted, refused, or withdrawn before a tribunal hearing commences.

2.4. Phase Three: Recruitment, interviews and focus groups

Phase Three involved the recruitment of participants using a purposive model of sampling thus allowing for the involvement of participants with a range of MHTS experiences. Participants from across different locations in Scotland, with a range of diagnoses of mental disorder, and from diverse groups including people with mental illnesses, learning disabilities, and people with experiences of forensic mental health services were sought to create a diverse sample. The purposive sample endeavoured to build a sample of maximum variation and is not intended to be a ‘representative sample’. Maximum variation sampling involves the development of a sample in which multiple different subgroups of participants are represented (Light et al., 2014). This means the research is not intended to be generalisable, rather the recruitment strategy allowed for the researchers to identify and detail a range of experiences and create a comprehensive understanding of experiences of the MHTS.

48 MHTS panel members comprising 13 legal, 16 medical, 17 general and 2 undisclosed members were recruited together with 38 health and social care professionals from across Scotland, comprising 12 independent advocates, 20 Mental Health Officers (MHOs), two Responsible Medical Officers (RMOs) and four solicitors. Additionally, 17 patients and 16 named persons took part in the study. The total study sample was 116 participants.

Certain demographic information about patients and named persons was collected to provide an insight into the variation among our sample. Patients and named person participants disclosed their age, gender, geographical location and ethnicity. We found an equal number of male and female participants among the named persons group while five patients identified as female, ten identified as male, one identified as non-binary and one did not disclose their gender. In terms of age, patient participants’ age ranged from 33 to 66 and named person participants’ age ranged from 40 to 77. Participants’ geographical locations varied mainly across Scotland, with a small minority of participants reporting a location in England. All participants who provided their ethnicity identified as white.

The recruitment process was such that a patient’s diagnosis of ‘mental disorder’ would only be known if they decided to provide that information. Disclosures of this nature were in fact insufficient to draw conclusions about different categories of persons with a specific mental disorder. However, in any event, the project focus was on experiences of the MHTS rather than diagnosis. Moreover, a diagnosis of a mental disorder can be complex and difficult to accept. For example, some patients diagnosed with a mental disorder dispute their diagnosis, or never receive a diagnosis that accords with their own experience and understanding of their own illness (Furimsky et al., 2008; Ridley et al., 2009).

2.4.1 Patient and named person participants

The first eight patients and nine named person participants were recruited through the MHTS which provided anonymised data to the study team. Potential participants were randomly selected from the identified categories by the study team and letters were then sent out in batches by the MHTS inviting potential participants to contact the study team if they were interested in taking part.

Following initial recruitment, it became apparent that the intended sample had not been realised, and consequently, additional recruitment approaches were utilised. During the second recruitment phase, participants received an invitation to participate in the study through gatekeeper organisations, including the Mental Health Foundation, See Me Scotland and SAMH, who circulated information to their members. Organisations also circulated information through networks and on social media. The study team invited named persons and patients to participate in the study via social media including LinkedIn and Twitter.

The team held a webinar in March 2021, providing an update on the study and encouraging patient and named person participation. Individuals from relevant gatekeeper organisations and other stakeholders including professionals from SAMH, Support in Mind Scotland, Alliance Scotland, Edinburgh Carers Council, and various advocacy organisations, among others, were sent invites to the webinar. Furthermore, the study team reached out to relevant organisations and provided individual or group presentations for staff members to encourage participation. Several organisations facilitated these presentations, including Advocard, the Scottish Independent Advocacy Alliance, Partners in Advocacy, Dundee Independent Advocacy Support (DIAS), and Caring Connections. Finally, the study team carried out a presentation at a SIAA roundtable event aimed at encouraging recruitment which was attended by representatives from a range of independent advocacy services.

Those interested in participating contacted the researchers for further information and to express interest in taking part. Only those participants who were demonstrably able to give full, free and informed consent were included in the study.

2.4.2 Patient and named person participant numbers

Whilst 17 patients and 16 named persons were recruited to the study, the original recruitment target of 60 patients and 20 named persons was not met.

There are various potential reasons why, despite strenuous efforts being made to recruit MHTS patients, anticipated patient recruitment targets were not met. Existing research shows that it is common for studies involving patients to fail to meet recruitment targets or even face cancellation due to low recruitment rates

(Jørgensen et al., 2014) with mental health studies being particularly affected, many facing systemic, cultural and individual obstacles (Pedersen et al., 2021; Leeson & Tryer, 2013). Gatekeepers may, for example, restrict recruitment owing to subjective judgments being made about the eligibility, vulnerability and resilience of potential participants (Borschmann et al.,2014; Williams, 2020). Gatekeepers may also have a lack of time or interest and knowledge to support the research (Allan et al., 2021; Patterson et al., 2010). Patients may lack motivation to take part in research through a perceived lack of an incentive or benefit to engage with the research process, lack of trust, the burden of participation, and lack of interest (Kaminsky et al., 2003; Woo et al., 2020). A person's lack of motivation to participate may also be disorder-specific, for example, the result of symptoms of depression (Bixo et al., 2021).

We experienced similar obstacles to recruitment in this study which were also exacerbated by Covid-19. The pandemic caused the study recruitment to pause for more than six months during 2020. When the study resumed in January 2021, we were informed by gatekeepers that their ability to support recruitment was adversely impacted by a lack of staff time and increased staff stress owing to many pandemic related changes to mental health services. The restrictions were felt to make it more difficult for services to engage with patients owing to the negative effect the pandemic has had on patients' mental health. Internet access, which would have potentially facilitated participation, was not necessarily available to all. The study's gatekeepers' experiences are in line with recent research (Thome et al., 2021; Chen et al., 2020; Tromans, 2020; Abbas et al., 2021; Dewa et al., 2021; Burton et al., 2021; Gillard et al., 2021; Mind, 2020; YoungMinds, 2020; Marshall et al., 2020).

Despite these recruitment challenges, we are, however, satisfied with the sufficiency and robustness of the data collected as we were able to draw some concrete recurring themes and issues from this. We were also able to compare this, to satisfy ourselves of its accuracy and consistency, with published evidence collected by the Scott Review (Scott Review, 2020), as well as survey data collected in 2019 by Vox Scotland on individuals' experiences of the MHTS (VOX Scotland, 2019) and the Mental Welfare Commission for Scotland (Mental Welfare Commission for Scotland, 2019).

2.4.3 Interviews

One to one, semi-structured interviews were conducted with patients and named person participants. Semi-structured interviews were chosen as the research method due to their ability to allow participants to express their views and experiences from their own perspectives whilst providing structure to ensure that research questions are addressed to enable data analysis (Bryman, 2016; Dickson-Swift et al., 2009). Prior to the onset of COVID-19, face to face interviews were conducted in an appropriate and neutral environment which was accessible to participants. After the onset of the pandemic, data collection methods moved online and participants were interviewed via a video conferencing platform, Microsoft Teams. Measures taken to reduce power imbalances between the researcher and the interviewees included giving participants full control over when the interview would take place and rapport building prior to the interview. Video conferencing was used as it has been found to generate data equal to or higher in quality compared to that gathered in face-to-face interviews (Lo Iacono et al., 2016). Specific advantages have been associated with digital interviewing, including improved time and cost-effectiveness and easy interview termination for participants, and rapport can be established just as easily as in person in most cases (Deakin & Wakefield, 2014). The interviews provided a confidential environment for participants to discuss their views and experiences of the MHTS. The interview questions focused on involvement with the tribunal, including information and understanding, participation, the quality of patient representation, legal representation and advocacy support, and perceptions of fairness.

2.4.4 Focus Groups: MHTS panel members and health and social care professionals

Twelve focus groups were conducted with recruited MHTS panel members and health and social care professionals. A meeting was also held with the Restricted Patient Team (Mental Health and Protection of Rights Division) at the Scottish Government.

MHTS Forum Members groups assisted with the recruitment of panel members. Information was provided in advance of the forum groups and, upon the provision of full, free and informed consent from members, focus groups were undertaken at these meetings. Advocates, solicitors and curators, MHOs, and RMOs were also recruited with the assistance of the Scottish Independent Advocacy Alliance, the Law Society of Scotland, the Scottish Association of Social Workers, and the Royal College of Psychiatrists. Due to a small number of solicitors and curators taking part in the focus groups it was necessary to conduct an additional phone interview to increase representation amongst this group.

Although less sensitive in nature to interviews focus groups are a useful method in qualitative research due to their ability to generate information on common experiences and shared concerns as well as their propensity to yield unique data built from group dynamics and a shared environment (Stewart et al., 2007). During the focus groups, a handout was provided detailing the Millan Principles, with participants asked which principles were most relevant to MHTS processes and decision-making and the extent to which MHTS panels proactively used human rights in their decision-making.

2.5. Phase Four: Data analysis

The fourth and final stage of the study involved the analysis and synthesis of the qualitative data collected during Phase Three, writing the final report and dissemination.

All interviews and focus group recordings were transcribed verbatim. Thematic Analysis (Braun & Clarke, 2006) was used to analyse the data. This approach to data analysis is commonly used in mental health research (Crowe et al., 2015) and is a useful method for examining the perspectives of different research participants and summarizing key features of a data set (King, 2004). The thematic analysis approach involved a number of steps. Firstly, the participants' data was anonymised. Transcripts were initially read and then re-read to facilitate familiarity with the data (Braun & Clarke, 2006). Coding was conducted by the study research assistants and themes and sub-themes were discussed and developed during research team meetings. Representative quotations were identified during the writing process. Transcripts were initially coded by hand, which involved identifying and organising themes and sub-themes. Subsequent coding, and refining of initial codes, was conducted on NVIVo 12.

The data was examined in relation to 1) standards required of the ECHR and CRPD, 2) legislative and human rights principles; and 3) the themes from the systematic literature review.

2.6. Ethical considerations

The study was designed to protect anonymity and confidentiality and all participant details have been fully anonymised within this report and all related publications. Only participants who were able to provide full, free and informed consent were included in the study. Standard and easy-read information sheets were provided to participants who were given the opportunity to ask questions before signing a consent form. Measures were in place to support individuals if they became upset during the interviews, however, these were ultimately not required. Debrief sheets with the details of support organisations were also provided to individuals taking part in the interviews.

Ethical approval was obtained from the Edinburgh Napier University School of Health and Social Care Research Integrity Committee (reference: SHSC0017) to conduct the study and from the NHS Southeast Scotland Research Ethics Committee 01 (reference: 259058) relating to anticipated recruitment from NHS sites.

Chapter Three: Findings

The overall objective of this research study is to identify different perceptions of how the MHTS processes and decision-making operates in terms of adherence to the Mental Health Act and international human rights principles and where developments and improvements may be made. This chapter provides details of findings from information collected from the interviews and focus groups referred to in Chapter Two. As stated in Chapter Two, we are satisfied with the sufficiency and accuracy of the data leading to these findings.

As the principles which underpin the Mental Health Act are often referred to as the “Millan Principles”, the focus group and interview data is presented firstly in terms of where it directly corresponds to them. The findings that relate to wider issues are then presented. Specific references to participants are abbreviated as follows:

LM- MHTS panel legal member

MM- MHTS panel medical member

GM- MHTS panel general Member

MHTS- MHTS panel member role unspecified

S- Solicitor

MHO- Mental Health Officer

RMO- Responsible Medical Officer

Adv- Independent advocate

3.1. Millan principles

3.1.1. Non-discrimination, equality and respect for diversity

The principles of non-discrimination, equality and respect for diversity were interwoven in the collected data forming a unified theme. These principles correspond to those found in sections 1(3)(g) and (h) of the Mental Health Act.

3.1.1. (a) Fundamental and unspoken principles

Non-discrimination, equality, and respect for diversity were often described by MHTS panel members as fundamental but unspoken principles underpinning the tribunal process (LM 1 GM 1 MM1 MM 3 MHTS 1 MHTS 3) in contrast to principles such as maximisation of benefit and the least restrictive option which receive more discussion.

‘I think I'd say I'm conscious of most of those things, most of the time. But the ones that are at the top there, which are non-discrimination and equality, I never think about these at all. Because I think we all assume, without even thinking, that we are discreet, you know, we’re not indiscriminate, and we’re not treating people unequally.’ – MHTS 1.

Two MHTS members stated that they had never come across discrimination towards patients at hearings although some MHTS members acknowledged that implicit bias can be difficult to recognise. It was suggested that further equality and diversity training be provided for MHTS members, such as LGBT rights and anti-discriminatory practice (MHTS 2). Similarly, a named person highlighted the importance of equality and diversity training for MHTS members to improve the practice.

3.1.1.(b) Adjustments and accommodations

Accessibility issues arising from language or literacy barriers were highlighted by some MHTS panel members and health and social care practitioners as potential obstacles to participation and causing delays. This was viewed as being particularly salient for those for whom English was not their first language. Various reasons for this were given such as a lack of forward planning and coordination, or the availability of interpreters (MM 2 LM 1 GM1 Adv 1 MHO 2) and confusion over who should assume responsibility for arranging an interpreter (GM 1 MM 1 C 1). MHOs suggested the MHTS could be responsible for arranging interpreters, while solicitors felt that the responsibility for such arrangements is with health services.

Other issues impacting on inclusivity and participation detailed by some participants included a hearing having to be adjourned owing to the incorrect text size on the paperwork (MM 1), the absence of signers (MM 1), and expecting translators to meet challenging translation needs (MM1). Panel members pointed out that the use of an interpreter could result in a lengthier tribunal hearing (MM1 LM 1 GM1) with a need for additional time to enable participation (LM 1).

A lack of support for people with hearing impairments and the absence of a loop in the tribunal room were also highlighted by some participants (MM1 MHTS 1). One named person with a hearing impairment explained that the tribunal was not appropriately adjusted to suit their needs, which led to difficulties in enabling participation at certain points during the hearing.

3.1.1. (c) Specific examples of non-discrimination, equality, and respect for diversity challenges

Gender identity was an element of equality and diversity discussed by panel member participants. Whilst some participants suggested it is incumbent on the tribunal panel to write reports using gender neutral pronouns (MHTS 2) some conveners did not view this as appropriate and misgendered patients based on their gender identity.

Men in their late 20s or early 30s with addiction issues and offending histories were also identified by one MHTS panel participant as requiring a greater understanding of their personal circumstances (MHTS 1).

Few patient participants directly referred to non-discrimination, equality, and respect for diversity. However, three patients felt that detention and compulsory treatment based on mental disorder is discriminatory and that patients should be afforded greater choice and autonomy through being able to meaningfully contribute to care and treatment decision-making. One patient felt that a diagnosis of mental disorder reduced the perceived credibility of their evidence at the tribunal and attempts to change their medication. One patient participant said that the experience of being legally required to take drugs, despite their side-effects which were perceived as harmful, was more distressing to them than their illness.

"For a panel to blindly accept this kind of statement is negligent. To give more credence to a doctor's opinions about issues affecting a patient's quality of life and to facilitate imposing a treatment based on these opinions is discriminatory. It would provoke an outrage in any other area of medicine. Discrimination in relation to my illness has occurred consistently exaggerating perceived risks to me and others in the community and consistently undermining my ability to apply rational decisions that I have made by myself when well."- Patient 1

Two named persons felt that MHTS panels judged them on the basis of their perceived socioeconomic class and appearance with a preference for those who appeared to be 'middle class'.

It was also highlighted that many patients at hearings are ‘White Scottish’ (MHTS 2) with one MHTS participant being of the view that panel members’ understanding of the intersection between different cultural practices was limited due to the small number of Black, Asian and ethnic minority (BAME) patients at hearings. A named person also identified misunderstandings over faith as an issue and described how a panel believed that a patient’s Christian belief system attributed to their psychotic symptoms.

3.1.2 Benefit, reciprocity and the least restrictive option

The principles of benefit and reciprocity correspond, respectively, to the Mental Health Act sections 1(3)(f)) and 1(6). The principle of the least restrictive option is reflected in section 1(4) MHA.

Patient participants engaged in limited discussion on the principles of benefit, reciprocity, and the least restrictive option, although several expressed views that the care they received in hospital was inadequate and in their view did not provide benefit.

‘But that wasn't really explored at the tribunal. I feel like it was a missed opportunity because actually, hospital was just not beneficial, it was actually incredibly detrimental, and I feel like the tribunal could have been an opportunity to catch that.’ – Patient 2

Some MHTS panel members stated that the principle of benefit is assumed within the tribunal as it is at the core of its process (MHTS 2). They also stressed the importance of providing care and treatment if there were to be restrictions of a patient’s liberty and autonomy due to them being detained. One MHO and an independent advocate felt, however, that reciprocity is often misunderstood, and the same MHO therefore felt that it was left out of hearing discussions. Another independent advocate said that the principle is not mentioned in tribunals.

One named person said that it was actually only because of their understanding as a professional that the Mental Health Act principles included reciprocity that they were able to challenge the RMO and encourage the panel to make a ‘recorded matter’ (see later) that contributed to the discharge of their sister from hospital.

‘I can't imagine most named persons going and reciting what the principles of the Mental Health Act are, but because I know what they are I can go in and I can use the language that they use, I can use the words that the professionals use and I think maybe it does put me in good stand in some ways. So overall it's sort of well actually you're just a sister or you're just a named person.’- Named Person 1

Some MHTS panel members mentioned the prevalence of the use of the least restrictive option principle in both decision-making (GM 1 MHTS 1) at hearings and in MHTS written decisions (MHTS 2). One example provided was that of a proposed care plan which was considered more restrictive than necessary in light of the level of risk involved. Another example given was concern about the use of multiple Short Term Detention Orders (which are not granted by the MHTS) over a period of years when a least restrictive alternative was a longer-term CTO.

MHO participants tended to focus on the meaning of the least restrictive option. It was felt that the least restrictive option is ‘at the core of the tribunal’s function’ with the role of the tribunal panel perceived as safeguarding against unnecessary interventions (MHO 2). Additionally, the principle was considered to ‘permeate’ the entirety of the mental health system (MHO 1). Two of the solicitor participants also felt that the least restrictive option is a key underlying principle of the MHTS understood as an impetus to provide patients with care in the community rather than detention in hospital and one which appears often in the MHTS’s written decisions. One independent advocate highlighted that panel members endeavour to implement the principle as much as possible, while another suggested that this role usually falls to the general member.

3.1.2. (a) The impact of resourcing

Health and social care resourcing was, however, frequently mentioned with the realities relating to the availability of appropriate care perceived as undermining the principles of benefit, reciprocity, and the least restrictive option (LM 1 MHTS 1). Examples provided pertaining to the benefit principle included cases where some patients were subject to long stays in hospital where treatment was no longer required as an in-patient (MHTS 2) and a lack of evidence-based therapy (including non-pharmacological interventions such as psychological therapies) to facilitate discharge to a less restrictive setting (MHTS 2 MHTS 3 MM 1).

‘I mean, to be fair, the problem with it, it usually boils down to a resource issue, which the tribunal, I think quite rightly, try not to get into,’- medical member no.1.

Some participants were of the view that using ‘recorded matters’ to ensure the principles of benefit and reciprocity, though justifiable, was often ‘pointless’ owing to the limited ability to enforce them and the lack of availability of appropriate services (MHTS 4 MM 1 LM 1).

Amongst health and social care professional participants it was highlighted that inadequate resources in the community may lead to patient deterioration and hospitalisation (MHO 1 MHO 3 S1). Delayed discharge (Adv 2 S1) and the inability to access services such as psychological therapies (Adv 1) were also attributed to a lack of resources in the community, preventing implementation of the reciprocity principle.

Discussing the least restrictive option, panel members felt that a lack of community supports, such as carers and supported accommodation (MM2 GM 1) and delayed transfer of patient care from hospital to the community due to a lack of appropriate support and accommodation (MM 1 GM 1) undermined the principle.

One advocate provided an example in which a patient spent years inappropriately detained due to a lack of appropriate housing in the community. This was detailed further by an advocate who revealed that in their area, a hospital ward had been opened to accommodate patients ready for discharge and unable to be transferred to the community due to a lack of suitable housing. Patients under interim CTOs and therefore subject to many MHTS hearings due to adjournments experienced longer detention than may be necessary (1). Some solicitor participants highlighted the detrimental effect long term hospitalisation can have on mental health and the need to give patients an opportunity to return to the community after long term hospitalisation (S 2).

"But it's least restrictive in the resources that are available I suppose is my point. If there's limitless resources you could do all sorts of things. I'm not saying there should be." – MM 2.

Patient participants provided differing views on the way in which the least restrictive option is implemented in practice. One patient stated that psychiatrists are open to discharging patients from hospital as much as possible based on risk assessments, whereas another patient indicated that they had been unnecessarily detained in hospital owing to their care team excessively focusing on risk at the MHTS hearing. One patient perceived involuntary treatment to have been necessary in hindsight. Another patient considered that community-based CTOs which required them to take medication as more restrictive than hospital-based orders.

Patients in secure hospitals who had engaged in appeals against excessive security with the MHTS provided a different perspective of restrictiveness to patients in the general mental health system. Patients detained in high and medium secure settings may apply to the MHTS against the level of their security with a view to this being reduced[15] One individual explained that it took 20 years and approximately as many appeals against excessive security to move from a high secure ward to a medium secure ward. The patient also said that it is common for people entering the system to have their order in place for years, or even decades, without review or change to the security under which they are kept.

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[15] Sections 264-271 MHA.

3.1.3. Informal Care

The principle of informal care is reflected in section 1(4) of the MHA requiring the MHTS to consider whether the proposed care and treatment can be effectively delivered in the absence of compulsory measures. This is closely aligned with the least restrictive option and benefit principles and reflects rights to autonomy and liberty, physical and mental integrity and independent living and participation in society.

The principle of informal care was highlighted by several MHTS panel members as being an important consideration for them with one participant suggesting that it may be particularly important to older adults who view the care of their spouse as their responsibility. Other participants saw informal care as an integral part of a patient's life but not necessarily something that was considered by MHTS panels with the General Member's background being perceived as fundamental in determining the MHTS's approach in this respect. One MHO pointed out that informal care avenues should be explored before applying for compulsory care and treatment and suggested that in their experience this does not always happen in practice (MHO 1).

Some of the patient participants commented that they could not recall the possibility of informal care being discussed or considered as part of the tribunal hearing and one named person discussed the care they provide for the patient on an informal basis, emphasising the important role carers have in patient's lives.

3.1.4. Participation

The principle of participation is reflected in sections 1(3)(a), (c), (d) and (d) of the MHA and is designed to ensure that the patient's wishes and feelings are heard in the tribunal process and its decision-making. There were varied views on participation at hearings.

Some MHTS panel members considered participation a focus at hearings (LM 1, MHTS 1, GM 1). They mentioned providing patients with the opportunity to take breaks was considered a facilitator to participation (GM 1, MHTS 1), as was rescheduling the tribunal hearing in the event of the absence of the patient and their representatives (MHTS 1). Some panel members talked of adapting their approach to the patient's needs by using less formal attire, the tone of their language, giving patients the opportunity to see the tribunal room or meet the panel prior to the hearing, and reducing the level of formality to promote inclusion for specific patients such as children, people with learning disabilities, and older adults (MHTS 1, LM 2 GM 2). It was pointed out that the ability of the tribunal panel to adjust their approach to suit patient needs varied, with some more skilled than others in promoting a participatory environment for all (MHTS 1).

Health and social care professional participants also stated that patient participation is crucial (Adv 2 MHO 1). Noticing patients and acknowledging the importance of the tribunal's decision to them was seen as encouraging patient participation, with most panel members viewed as behaving in this way (Adv1). An independent advocate felt that informal discussions, and in particular recognising when a patient wants to speak and encouraging them to do so positively facilitated participation (Adv 2). One solicitor pointed out that MHTS panels always prioritise the participation of patients (S 2):

"And I think most [conveners] are good. It's that smile, that making the patient the focus, speaking to them first and foremost and saying this is what we're doing today and this is what it's about and we're going to...you know, and explaining things in a calm manner and a slow manner and allowing the patient to have some say."- S 1

Best practices for panel members identified by the independent advocates included responding to patients who are visibly upset or wished to contribute to their hearing, using positive body language, and tailoring their approach to patient needs (Adv 2). Panel members 'visiting' patients too unwell to leave the ward to participate was highlighted as a useful approach to enabling participation (GM 1 LM 1 S1 Adv 1 MHO 1) although the extent to which it was possible is in part dependent on risk assessment guidelines (MM 1 LM 1).

Five of the patient participants felt that the MHTS panel provided opportunities to contribute and express their views. One participant described being actively encouraged by the tribunal panel to contribute to their hearing, feeling that the panel were eager to hear their views and for them to participate. The same participants explained that they were able to write to MHTS to have the hearing date changed, which they considered to be helpful and supportive.

'I was given the opportunity to say what I wanted to say. I think that that was important, and I think it would have been very inappropriate if I hadn't been given the opportunity to represent myself. – Patient 3

Another patient participant felt that relationship building with staff in hospital was important as it helped them to participate in their hearing. One patient stated they felt encouraged to speak, that the MHTS panel were interested in what they had to say and were confidently and articulately able to present their point of view. This participant felt that they enjoyed their tribunals and benefited from taking part in the hearings, having the opportunity to take part in their own care and treatment decisions and enhance the tribunal panels' understanding of their journey.

While named persons portrayed differing views of their own and the patient's participation at the tribunal, the majority expressed positive views. The majority of named persons (9) said that their voices were heard and that they were given sufficient opportunities to participate.

However, despite evidence of good practice, various factors which impede patient participation were identified as follows:

3.1.4. (a) The impact of ‘mental disorder’ and clinician perceptions of risk

The effect of mental illness was perceived by some MHTS panel members as impacting on patients’ abilities to participate (GM 1 MM 1). Some panel members felt that patient participation should be limited in certain circumstances, as some individuals may dominate the conversation (GM1 LM 1) due to symptoms of their mental illness such as, for example, mania. However, two MHOs were of the view that patients should be given the opportunity to contribute to the tribunal even when they are ill and found it difficult to control their emotions. One patient participant described their mental state as negatively impacting on their ability to contribute to the tribunal, and this view was mirrored by one named person. A further issue that was mentioned was that the patient might not feel well enough to attend the hearing (Adv 1).

One independent advocate mentioned that patients might be prevented from attending a hearing because nursing staff have decided they are too unwell to attend (Adv 1). However, once there, the presence of clinical staff may also inhibit participation. One individual felt that although they had felt encouraged by the panel to participate it is particularly difficult to discuss issues or criticise their quality of care at the tribunal when the care providers are present, fearing repercussions.

Risk assessments were described as possible barriers to participation (MHTS 3 GM 1 LM 1), with some patients being considered too unwell to take part in their hearing safely although it was also suggested that nurses may overestimate the level of risk that prevented patients from participating in their tribunal hearing (GM 1 MM 1).

Some solicitors highlighted situations in which patients were detained in a hospital other than the one in which the hearing was taking place. This presented a practical barrier to participation due to concerns regarding possible absconding.

3.1.4 (b) Distress and formality at hearings

Three MHTS panel member participants identified the distressing process of MHTS hearings as an impediment to participation for some patients. Participation amongst child and adolescent groups was described as more limited than amongst adult patients (MHTS 1). Participants described adolescent patients as less likely to attend their tribunal and more likely to feel anxious during the hearing (MHTS 2).

Across the health and social care professionals group, it was felt that the level of formality of the tribunal hearing may inhibit participation for some patients (S 1, MHO 1).

One named person who expressed confidence and positivity about contributing to tribunal hearings explained that the formality of the tribunal may act as an impediment to participation for those less confident speaking in a formal setting.

‘But I could see why, if you were a different kind of person, why you wouldn't want to speak up. Because sometimes it does feel so formal, and you've got all those professionals there and you're thinking ‘oh’. I could see why some people would maybe be nervous about talking, or giving their opinion, or, just even going, I could see why people would be sort of intimidated.’- Named Person 2

It was stated by one named person that although participation at a tribunal hearing could be difficult and upsetting for the patient involved, for them it was less so. Two named person participants admitted that they actually hoped that their views would be given less weight by the tribunal than professional views because they did not want to appear to the patient as being responsible for their potential detention.

3.1.4. (c) The nature of the hearing

The role and approach adopted by the MHTS panel, and in particular the convener, was viewed as pivotal in creating an inclusive tribunal hearing (MHTS 1) with some conveners adapting their approach to suit the needs of the patient whilst others prevented patients from speaking when evidence was presented which for some was thought to limit participation (MHTS 2 Adv2). An independent advocate identified their role as instrumental in supporting patients to interrupt the Convener (Adv 1) more confidently. One solicitor participant pointed out that the approach of the convener was viewed to either encourage or inhibit participation, with more formal and legalistic conveners described as less likely to create an inclusive tribunal hearing (S2). One patient explained that the extent to which they could participate varied depending on the tribunal convener and panel.

Some participants reported that conveners do not always give their full attention to patients when they are speaking (MHO 1, Adv 1), and one solicitor explained they observed a convener using their phone while the patient gave evidence. However, two solicitors said that only a small minority of conveners did not give their full attention to patients.

The order of speaking in hearings was generally seen as pivotal to effective participation. Some MHTS panel members and practitioners stated that hearings adopted a distinct order in which patients were often invited to contribute at the end of the hearings. Some participants felt that tribunal panels should adjust the order to suit patients' needs rather than limiting them to the end of the hearing (MHTs 1 MM 1 Adv 6 MHO 1 S1). Two independent advocates felt that hearings in which patients are given the option to speak first facilitated their participation, although this rarely happened. Another independent advocate felt that while allowing patients to speak first is happening more often now, not all conveners used this approach. It was suggested by one MHO that patients who struggled to concentrate throughout the tribunal process may want to speak at the outset of the hearing. Patients' views generally suggested that panel members who enacted a strict order to the proceedings and forced them to speak last negatively impacted them. It was also pointed out that listening to evidence without an option to respond could be distressing for some patients.

Panel Convener flexibility on the order of proceedings was widely identified as an important facilitator to effective patient participation in their hearing with health and social care professional participants stating that conveners were instrumental in determining the evidence-taking sequence (RMO 1 S 1).

Another concern that was noted across the participant groups was that the encouragement of patient participation was perceived as superficial. It was suggested that participation is a 'tick box' exercise by two independent advocates and one MHO. Three independent advocates felt that participation was superficial, or that panel members encouraged participation only because of legislative requirements and not as a reflection of a genuine desire to support autonomy. A similar view was held by one solicitor:

'And when a patient has plucked up the courage to actually give their views at their tribunal and that's what they're met with, they'll stop talking. Okay, they've been formally recorded on the day as having been given the opportunity to participate. In reality, it's not really happening' – S 2

It was suggested by several health and social care professionals that some conveners appeared to have decided the hearing outcome prior to patient involvement, giving the impression of a foregone conclusion (Adv 2 S 1 RMO 1). This view was shared by a general MHTS member.

Many patient participants (9) felt that the panel discounted their views. Whilst they were listened to in a literal sense, they felt that their views on care and treatment and medication were disregarded by the panel. This view was supported by another patient who felt that the tribunal were prepared to listen to evidence from the RMO and MHO for a longer time and more attentively than for their evidence. One of the patient participants who was encouraged to contribute felt that being encouraged to take part would 'satisfy the tribunal more than it would [themselves]'.

One patient participant felt that the panel did weigh up the evidence and consider it all before reaching a conclusion, but several other patients participants expressed the belief that the decision was made in advance of the hearing by the panel (5) and felt that there was little reason to attend a hearing because they knew the outcome would reflect the RMO's wishes. One patient participant described the verdict as being "pretty much cut and dry from the minute they submitted the paperwork" with another stating that the panel members had 'pre-conceived verdicts' after reading the application in advance of the hearing.

"My experience of the tribunal was very negative. I was able to participate, this was after all the professionals had spoken first, the panel seemed to have made up their mind in favour of professionals before I had a chance to participate"- Patient 4

3.1.5. Information, understanding and support for patient participation

The importance of providing appropriate information and support to enable patient participation is reflected in section 1(3)(d) and is integral to full and effective participation and underpins the right to autonomy and exercise of legal capacity (Articles 8 ECHR and 12 CRPD). Various forms of such support exist including those which are recognised under the Mental Health Act such as independent advocacy and advance statements, and other forms of non-statutory support.

3.1.5. (a) Independent advocacy

The Mental Health Act[16] places a duty on local authorities and NHS Boards to provide independent advocacy for everyone with a diagnosis of 'mental disorder'. Independent advocates provide support to patients prior to the hearing, and may support patients to contribute during the hearing (Scottish Government, 2005).

There was limited discussion of independent advocacy services by MHTS panel participants. One participant highlighted the positive and helpful nature of advocacy services, and their efficacy in supporting participation for patients who struggle to speak during the tribunal (LM 1). Some MHTS panel members did mention that they felt that the quality of independent advocacy varies depending on the area or the individual advocacy worker's approach (LM 1 MM 1 MHTS 1). A few MHTS panel participants spoke about advocates who have failed to provide the patient with support, raising inappropriate topics at the hearing or tried to take over the role of solicitor. (LM 1 MM 1).

Health and social care professional participants focused on the benefits of independent advocacy, particularly in supporting patients to participate in their tribunal hearing (Adv 2 MHO 4). Some spoke about the benefits associated with

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[16] Sections 259-259A Mental Health Act.

independent advocacy workers building relationships with patients prior to the hearing (Adv 2 MHO 1) and noted that advocacy work often takes place behind the scenes rather than at the tribunal hearing, in informing patients on what to expect at hearings, managing expectations, and helping prepare written statements (Adv 3 S1).

The topic of independent advocacy support was polarising for the patient participants, with some positive views of such advocacy whereas others were more negative. Independent advocacy services were generally seen as primarily providing benefit to patients who lacked confidence or struggled to communicate at hearings but being of limited use to individuals who are confident and articulate enough to challenge the panel. Many participants benefitted from using advocacy services (6). Support in filling in forms, arranging a solicitor (2), confirming inaccurate information presentation (1), and appealing the tribunal were cited as benefits (2), alongside explaining the tribunal process and providing support to process the tribunal's decision. One participant felt that, although they did not require their advocate to speak for them at the tribunal hearing, they invested time into their relationship and provided support.

A number of patient participants mentioned that they declined to use or were not aware of their rights to independent advocacy (6) whilst other participants did access independent advocacy (8). Some of the patients who had used independent advocacy in the past but found it to be ineffective decided not to use it for more recent hearings (3). Another named person explained their son had not chosen to use independent advocacy support as he felt his named person fulfilled this role for them. One patient participant felt that independent advocacy services promised more than they could deliver. Some participants expressed negative views around advocates' abilities to provide support and benefit (5). Some participants described advocacy support as 'useless' (2) or lacking in efficacy to make any difference to the tribunal (2). Example problems included advocacy workers meeting the patient only prior to the tribunal; patient difficulties communicating with their advocate; advocates neglecting to be present at the tribunal; and the perception of their advocate as deceptive and in collusion with the RMO (2).

3.1.5. (b) Advance statements

Sections 275-276C of the Mental Health Act recognise the right of a patient to make an advance statement detailing the ways in which they do and do not wish to be treated and requires both the MHTS and clinicians to have regard to such wishes. Where a patient's wishes expressed in an advance statement are overridden by the MHTS or clinicians then the reasons for doing so must be recorded and supplied to the patient, and, where they have been appointed, the patient's named person, welfare attorney and guardian as well as the Mental Welfare Commission for Scotland[17].

MHTS panel participants highlighted the importance of advance statements, that they are given ‘special attention’ when available, and that the tribunal panel actively enquire as to whether one has been made (MHTS 3 MM 1 GM 1). Some felt that the use of advance statements at hearings has increased (GM 1 MM 1) while one participant suggested the opposite (MHTS 1). Participants also highlighted procedural errors sometimes result in the accidental omission of an advance statement from the paperwork at hearings (LM 1 MHTS 3 MM 1):

‘I wouldn’t say it's frequently, but certainly, you know, in a couple of tribunals, over the course of the tribunal, it's become apparent that, in fact, there is an advance statement, although the paperwork from Hamilton that had been sent out, indicated that there wasn’t.’- MHTS 2

There was, however, agreement amongst the MHTS panel and health and social care professional participants that advance statements are rare at MHTS hearings (LM 2 GM 3 MM 2 MHTS 6 MHO 3 S2). MHTS panel members suggested that patients and named persons are often unaware of the patient’s right to make an advance statement and of the importance of such statements in panel decision-making (MM 1 MHTS 1).

Solicitor participants also stated that advance statements could be very helpful for patients (2). Some MHTS panel participants suggested that patients may be too unwell to develop an advance statement (LM 1 GM 1 MM 1), and that some patients may also be unwilling to develop one owing to a reluctance to accept they may become unwell again thereby necessitating the use of their statement (MM 1 MHTS 1). A MHTS panel participant also mentioned that it is important to check whether old advance statements have been updated or are still relevant during the tribunal (MHTS 2).

Some MHO participants felt that the development of advance statements is not seen as a priority in discussions with patients (2), with the effect of limited resources and therefore the time MHOs can allocate to this being provided as a reason.

Patient participants’ understanding of advance statements varied. Eight reported that they had had an advance statement at the time of the tribunal and seven of these patients felt that their advance statement was not given due consideration by the tribunal, with five reporting that their advance statements had been overridden without adequate explanation.

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[17] Section 276(8) Mental Health Act.

‘I was quite upset about that, but people have said that, actually, they just hadn’t accepted the advanced statement as being valid in the first place. Certainly, they never reported it to the Mental Welfare Commission, or gave an explanation of why they didn’t respect those wishes.’- Patient 5

One patient also felt that they were misinformed about advance statements by their Community Psychiatric Nurse which undermined their ability to create one.

3.1.5 (c) Information and understanding

For patients to meaningfully participate at their tribunal, they must be provided with sufficient information to understand the process. Health and social care professional participants explained their role in providing information for patients. One advocate explained that their job often involves resolving patient anxieties about the tribunal hearing process, such as delineating between the tribunal and a criminal trial (Adv 1). The MHO participants highlighted the inadequacies of the information provided to patients and named persons regarding the tribunal hearing process. This included the volume of reports (MHO 1) and that information on the named person role, which must be found online and printed (MHO 1). In contrast to this, one MHO participant was positive about their role in providing information to patients. The solicitor participants highlighted the anxiety experienced by patients who do not know what to expect at the tribunal hearing process.

‘Really, their degree of anxiety about what to expect. It seems to be…and this is quite a sweeping comment, but it seems to be not knowing what to expect or expecting the unexpected, I suppose. I think they go in with a degree of trepidation, and on some occasions that I think has exacerbated their mental health.’ – Solicitor 3

The accessibility of information to patients was determined by the approach of the tribunal panel, which varied (Adv 1) with most seen as skilled in flexibly adapting their approach to suit individual needs.

‘And I think it really depends on the panel. Sometimes the panel are great, and they are, they explain things in really simple terms, and the patient can understand, they're very mindful of the patient’s presentation. And if they are kind of butting in, and things, they don't shut that down.’ - Adv 1

Six of the patient participants described receiving no verbal or written information or preparation for their tribunal hearing. Three participants reported receiving very limited information, such as an invitation letter or the written copy of the CTO application, but did not receive any further information to help them understand the tribunal process and adequately prepare for their hearing. In contrast, five stated they had discussed the tribunal with their advocate, lawyer, MHO, or RMO.

Some MHTS panel participants mentioned that legalistic, medical and complex language can make it difficult for some patients to understand both the hearings and the report setting out the panel’s decision, the Full Findings and Reasons Report (FFR) (MM 1 GM 1). Legal participants stated that the reports must be written using legal and medical language due to GDPR requirements and because of the nature of the tribunal as a ‘court process’ which necessitates a high level of formality. Patient participants agreed with the view that this style of language impeded their ability to follow the tribunal hearing process.

‘I never knew what was going on, it was just the way they talked too fast, you couldn’t get your voice in, you know what I mean?’- Patient 6

3.1.6. Respect for carers

One general MHTS member participant expressed the importance of promoting carer participation. Participants explained that they often adjust their approach to limit the amount of information lost from the exclusion of carers from the tribunal. Another participant described a mother and primary carer who was excluded from the tribunal (MHTS 1) which was due to perceived panel inflexibility (MHTS 1). One panel member felt that more consideration around respect for carers should be taken, without crossing the boundary of patients’ rights (MHTS 1). Panel members spoke of situations where patients specifically request that their family member or carer is excluded from the hearing, necessitating the balancing of patients’ rights with carers’ rights, despite the useful insights that could be lost when not permitted to give evidence (GM 1). In these situations, it was felt that the respect for carers principle may be in direct conflict with the maximisation of benefit principle and patient’s rights to respect for private life (MHTS 3).

3.1.7. Child Welfare

The child welfare principle describes the requirement for panel members to prioritise the welfare of any child with a mental disorder who is facing an intervention and is reflected in section 2 Mental Health Act.

The child welfare principle was felt to be quite specific to the small number of tribunals in which children are involved (MHTS 1). Not all panel members sat on children and young persons (under the age of 18) hearings, which were introduced in 2012, so not all had experience of these hearings. One participant highlighted that sitting on child and adolescent tribunals is specialised, with panel members who sit on these hearings provided with additional training. Participants felt that the changes to children and young person’s hearings introduced in 2012 have improved young patients’ experiences with panel members now being more ‘alert’ to issues concerning them. It was stated that some conveners are particularly skilled at creating an inclusive environment for children and young persons (MHTS 2 GM 1). In some cases, there was also some confusion about whether the child welfare principle referred to the child or young person as a patient or the dependent children of an adult patient.

Health and social care professional participants also perceived an improvement in the treatment of children and young persons at hearings, whilst some also highlighted the effects that detention in a psychiatric hospital can have on the future of young people, questioning whether detention is always appropriate for young people (2). One of the solicitor participants suggested that some MHTS panel members sitting at child and young persons hearings do not have the skills necessary to relate to children and include them in the process although it was also stressed that this is the exception as most panel members recognised the distinct needs of young people. It was also suggested by one solicitor participant that doctors will only seek to detain a child or young person when necessary.

3.1.7. (a) Child protection issues

The issue of panel members’ role when child protection issues were raised where their parent was a patient was also raised by MHTS panel members. One MHTS panel member said they felt unclear about how far panel members’ responsibility regarding child protection went (MHTS 1). Some felt that the patient was the sole focus of the tribunal, and that whilst queries can be made about dependent children at the hearing, it is in fact the role of social workers and MHOs to pursue this (MHTS 1 LM 1).

3.2. Wider Issues

3.2.1. Human Rights

The study participants were asked to what extent MHTS panels actively consider and address human rights in their decision-making. Some MHTS members reflected that there is limited knowledge of specific human rights articles and how these apply to the tribunal (MHTS 2 LM 1) with one MHTS panel participant identifying the need for training on human rights and the implications for their role.

'I'm going to be controversial and say I suspect a lot of the people on tribunals don't know what the human rights are, what the different human rights are, but I wouldn't say they are not using it because I think some of these things are human rights; so, it's the underlying embedded aspect of it. Thinking about your family rights and all the rest of it; all that's thinking about human rights, although people won't recognise that's what they're doing.' – LM 1

However, whilst human rights do not appear to be explicitly discussed at hearings, the prevailing attitude across MHTS panel participants was that human rights are enshrined in the panel's approach and operation of hearings (MHTS 5 LM 2). Generally, participants observed that it was, however, rare for a solicitor to base representation around a breach of human rights (MHTS 2 MM 1). Some panel members specifically referred to patients' right to respect for private and family life as prominent (MHTS 5 LM 2), and one MHTS panel participant indicated that this right is at the forefront of tribunal decision-making. The right to a fair hearing was also considered to be important by some panel members (MHTS 1 LM 1) as well as the issue of avoiding a deprivation of liberty occurring in relation to community-based CTOs and Compulsion Order and Restriction Orders (CORO) (MHTS 2). Discussion of the CRPD was viewed as even less common than ECHR rights by some panel members (MHO 1 S1 MHTS 2).

Health and social care professional participants specifically referred to the right to private life and family life (RMO 1), the right to a fair hearing (S1) and deprivation of liberty in terms of human rights (Adv 1) as having a significant influence on the MHTS panel. However, one RMO suggested that the degree of the consideration of human rights at hearings is unclear until the FFR is produced, and other participants felt that even the FFRs do not mention human rights explicitly although they do reflect the Millan Principles instead (RMO 1 S 1).

Patient participants discussed the extent to which the MHTS upheld their rights. One participant highlighted the gap between the choice and autonomy afforded to mental health patients and the substantially wider scope for choice and autonomy afforded to non-psychiatric patients. Six patient participants expressed positive views about the MHTS’s adherence to human rights principles, with the right to advocacy and the benefit of participation to patients being cited as the most notable mechanisms for upholding rights. Supported decision making was identified by one patient as another mechanism to promote patients’ rights.

3.2.2. Perceptions of fairness

3.2.2. (a) Role of the panel

MHTS panel participants were of the view that the degree of patient participation was the most important factor in determining patients’ perceptions of the tribunal process (MHTS 2 LM 1 GM 1). This view was mirrored by an independent advocate who said:

‘And if they feel that they were part of the discussion beforehand, and part of the presentation, even when they don't get the right result for them, then they can live with that an awful lot better, than if they hadn’t participated. Because they're left in a situation thinking, well if only I had spoken to them, it might have been a different result.’ – Adv 2

Nine named persons felt that the conveners conducted the hearings fairly and three felt that involvement in discussions and the opportunity to challenge evidence contributed to fair treatment of both named persons and patients. However, another three named persons felt that the tribunal process and outcome were unfair, whilst another said that the power imbalance between professionals and non-professionals at the hearing undermined its fairness.

‘I do not doubt that the tribunals were well-intentioned and wanted the best for my mother (whom they had never met). But they were unaware of their own biases, and that they were basing their decisions on guesswork and prejudice rather than a test of evidence and the advice of the Handbook. They first decided what outcome they wanted then selected the evidence to fit, ignoring everything to the contrary.’ – Named Person 3

One patient felt that their RMO had intentionally provided the panel with misinformation to make a compulsory order more likely, and another patient participant felt that hospital staff exaggerated perceptions of risk to make approval of an order more likely.

3.2.2. (b) The balance of power and the power of the medical domain

To test and ensure the lawfulness of any proposed measure and to safeguard a patient’s autonomy against inappropriate interferences, as required by the Mental

Health Act, it is essential that there is a balance of power between patients, clinical and social work professionals and the MHTS panel.

Some health and social care professional participants spoke about the unequal power differentials within the mental health system and how this also impacts on patients during the MHTS process (Adv3 MHO 1). It was suggested that MHTS panel members were sometimes viewed as silencing patients and preferring medical evidence (Adv2).

The balance of power was a particular focus of many patient participants who described power imbalances between them and their RMO. Twelve patient participants perceived medical evidence to be viewed by MHTS panels as paramount and therefore given greater weight than the patient's evidence.

'*As I said, if you're backed by the doctor they'll generally be successful and if you're not they generally won't be. It kind of makes them seem a bit pointless if you see what I mean?'* – Patient 7

Eleven patient participants described feelings of powerlessness within the MHTS process, perceiving RMOs to hold the power over their care and the MHTS hearing outcome. Three patients spoke of feeling a loss of control at the tribunal hearing with the outcome, if an application for compulsory treatment was granted or an appeal denied, further reinforcing feelings of powerlessness. One patient and named person felt that MHOs tended to agree with the RMO evidence without scrutiny despite the questions about the accuracy of the evidence presented. One individual felt that solicitors are ill-equipped to challenge medical evidence at the tribunal as they generally don't have enough time to build a relationship with the patient. Some patient participants were of the view that some panels 'rubberstamp' the RMO position (7), citing the rates of order acceptance by the MHTS as sitting between 97% and 99% (4). From the MHTS data collected by this study, during the period of 2006 and 2017 71.04% of applications were granted. Conversely, one person felt that although the tribunal decision always aligns with the doctor's view, the process considers all information presented.

Some health and social care professional participants felt that there was not enough testing of the evidence by MHTS panels and that inaccuracies in the RMO's evidence were not adequately scrutinised (NP 5 RMO 1).

'Looking at one of the papers, actually, about the…patients feeling that the kind of psychiatrist's opinion is just very dominant and where that contradicts with anyone else, it's just immediately assumed that that's right. I'd rather have to justify it.'- RMO 1

One independent advocate also pointed out that tribunal panels can give patients the impression that evidence is weighted with RMO evidence preferred, which is difficult to explain to patients.

Named persons' views reinforced patients' perceptions of feeling disempowered, inferior (5), and helpless (3) by the process. Concern was raised over inaccuracies presented to the tribunal panel by RMOs and MHOs. Two named persons reported that inaccuracies were not scrutinised but accepted, and the responsibility to clear these up lay with them. One explained that the patient's offending history was misrepresented in the MHTS reports. Such inaccuracies led some patients to doubt their own knowledge of their personal history and accept erroneous information.

'And then, even though there were glaring inaccuracies in their presentation and their reports to the tribunal, the word of the RMO was taken almost as sacrosanct and, as truth when it wasn't, and the MHO just, really just copied what the RMO had said in her report and just, almost word for word and so nothing new to add.' – Named Person 4

3.2.3. Impact on relationships

3.2.3. (a) Non-professional relationships

Several patient participants described relationship tension and breakdown caused by the tribunal process. One participant spoke of the need to discuss the tribunal process beforehand and make agreements to protect their relationship with their named person for the future. Another felt that their named person attempted to control them, and the tribunal experience adversely impacted their relationship permanently. Another said that their named person refused to believe their perspective and this lack of trust resulted in them revoking the person from their named person role and one patient participant spoke of relationship strain caused by the named person's anger at the system. However, two participants felt that the involvement of their named person in their tribunal resulted in relationship strengthening and had a positive impact. Two named person participants similarly said that working towards the same outcome for the patient resulted in an improved relationship.

3.2.3. (b) Professional relationships

MHTS panel participants discussed the effect that adversarial proceedings in the tribunal can have on patient relationships with their RMO. Solicitors who take an adversarial approach to hearings or worked in criminal law were viewed as having an impact on clinical relationships (MHTS 1 LM 1). Some suggested that solicitors might lack an appreciation of the need to preserve the patient and RMO relationship (MHTS 1 LM 1).

Adversarial tribunals were seen by health and social care professional participants as resulting in patients seeing their RMO, MHO and CPN ‘in a different light’ and feeling emotions such as anger towards their care team (MHTS 1). One MHTS legal member suggested that solicitors working in mental health law should receive training regarding this (LM 2).

Health and social care professionals also felt that excessive questioning by solicitors leads to adversarial proceedings (RMO 1 MHO 1). Solicitor participants, on the other hand, discussed the delicate balance between preserving the patients’ relationship with the RMO (which was seen as important) and expressing their dissatisfaction with actions carried out by RMOs that are perceived as unacceptable (S2).

Patients discussed factors which undermined their relationship with their RMO. One participant felt that their RMO had not spent enough time with them to appropriately present evidence at the hearing. A named person described disappointment at the MHO and RMO’s professional behaviour, which was described as unscrupulous with inaccurate information presentation and a lack of prior knowledge of the patient’s history. Some participants described a difficult relationship with their RMO, with frustration caused by inequalities in power, perceived coercion, and inaccuracies in information presented at tribunal hearings.

“I’ve never met Dr. [name] before the thing. Or if I had, only for about five to ten minutes. She takes up opinions, and comes out with false allegations, and different things.”- Patient 8

However, three patient participants spoke of the positive relationship with their RMO. One said that their psychiatrist acted according to their best interests. Another explained that they felt no need to challenge their psychiatrist during their time in hospital or at the tribunal as they believed that their RMO knew best and they ultimately had full control over the patient’s care and treatment. Two named persons reported positive relationships with the patient’s RMO and a trusting relationship with the patient’s RMO meant that one named person was able to agree with the RMO’s views at tribunal hearings.

3.2.4. Named persons

A person aged 16 or over may appoint a ‘named person’ to protect their interests at a tribunal hearing. A child under the age of 16 cannot nominate a named person and a person with parental responsibilities for them will automatically assume this role. A named person may or may not also be the patient’s carer or family member.

Named persons must be nominated, with the proposed named person's consent, by a patient but only when they have capacity to make this nomination[18]. The former Mental Health Act provision allowing the MHTS to appoint a named person where a patient had not made such a nomination was removed by the Mental Health (Scotland) Act 2015[19] for patients aged 16 years and older and all named person appointment now happen due to patient nomination.

3.2.4. (a) The named person's role

Named person participants described some benefits of attending the tribunal hearing. These included being given the chance to clarify and where necessary, challenge evidence and information, to contribute to the decision-making process regarding the care and treatment of the patient, to be given the chance to speak to the RMO, to contribute to the discharge of the patient from hospital and to provide support to the patient during the tribunal process.

"I think it was good to be there. I think we were able to contribute a wee bit. I mean you obviously wanted to be there to be a kind of representative for her as well and to know what people were saying, because it was us that would eventually be left to pick up the pieces, these people would all walk away from the situation."- Named Person *5*

Some named persons were happy with the opportunities provided to participate and felt they were treated with respect or that their views were fully considered. However, they also spoke of difficulties with the tribunal process and the lack of clarity around such roles such as not receiving information regarding their role at the tribunal hearing and having to find this information out independently online (4) and not being informed that participation in the tribunal was optional.

'*So, she told me about it I phoned the MHO and said is this right and he said 'oh, yeah, forgot, yeah, sorry you can be there as the named person'. I'll send you some information about it. So, I feel like if I hadn't chased this up, which I'm finding a lot, I don't chase things up, and know to chase things up, nobody tells me nothing*.'- Named Person 6.

Five named person participants felt that no attempt had been made to involve the patient in the tribunal and seven named persons felt that their views were not fully taken into account or felt that genuine participation was not facilitated, with one pointing out the valuable contribution a named person can bring to the hearing.

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[18] Section 250 Mental Health Act.

[19] Section 22(2) Mental Health (Scotland) Act 2015 repealing section 251 Mental Health (Care and Treatment)(Scotland) Act 2003.

'I've been to half a dozen tribunals. I mean, some convenors are very good but it's the minority, most of them regard you, the named person as a bit of a sort of afterthought, yes. I mean, they know you're a party but they don't really treat you like a party.' – Named Person 7

One named person participant felt that they were not given a chance to ask questions of the RMO or MHO and in fact one named person said that supporting the patient in disagreeing with their RMO led to them being labelled as 'obstructive'.

An independent advocate said that when named persons cannot attend a hearing the named person is often not acknowledged by the tribunal, with none of their views read out and no representation. They felt that as the named person had been invited to the hearing this was the least the panel could do.

3.2.4. (b) Impact of removal of 'default' named person

Several MHTS panel members and MHOs talked about concerns about patient support at hearings being reduced by the removal of the 'default' named person provision by the Mental Health (Scotland) Act 2015 amendment. Whilst it was accepted that this was introduced with a view to respecting a patient's choice and privacy[20] some MHTS panel participants felt that the new provision might disadvantage patients and described the resulting exclusion of carers of vulnerable people as 'upsetting' and a 'sad irony' (GM 1, MHTS 2, LM 1). Some participants stated this was particularly upsetting for carers who provide life-long care to their family member (MHTS 3 LM 2). Possible options for carers who were once named persons by default and were removed from the role by this recent provision were discussed. One option for carers is to request to become 'listed initiators'[21], where they are the patient's guardian, welfare attorney, primary carer or nearest relative[22], as a mechanism for inclusion in the MHTS hearing process (MHTS 5 GM 1). However, these roles were understood as inadequate substitutes for the level of involvement that is afforded to named persons (MHTS 1). In contrast, the unfamiliarity of the provision was recognised, and some participants suggested that issues may subside as professionals become more accustomed to the new system (LM 1 MM 1).

'Many more people since the provisions came into place, are coming to tribunals without a named person. Whereas, they would have had someone there.' – LM 2

Several participants across the groups perceived the 2015 amendment as a justified yet flawed attempt to solve a difficult situation (MHTS 2 MM 1 MHTS 2 MHO 1).

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[20] Article 8 ECHR (right to respect for private and family life).

[21] Section 257A Mental Health Act.

[22] Section 257A(9) Mental Health Act.

3.2.5. Patient representation

3.2.5. (a) Solicitors

Some panel members and health and social care professionals discussed the significance of legal representation in safeguarding patient rights and the Millan Principles (MM 1 LM 1 MHTS 1 MHO 1) and testing and challenging the evidence presented (MHTS 1). Whilst the importance of solicitors for patients was recognised, several adverse effects associated with solicitors attending hearings were identified, such as contributing to a ‘them against us’ impression for patients (GM 1), creating false hope (MHTS 1) and building a more formal and legalistic environment. Participants also discussed whether solicitors raised human rights arguments when cross-examining evidence. However, it was commented that solicitors tended to focus on the criteria for compulsory measures and the Mental Health Act principles when making their arguments (MHTS 1).

The quality of legal representation was viewed as varying depending on the solicitor’s approach, level of experience and skill. Tribunal panel participants emphasised that most solicitors are proficient in their role and have a genuine interest and are skilled in mental health law (GM1 LM 2 MHTS 3). However, participants highlighted that a minority of solicitors provide poor representation to their clients (GM 2 LM 2 MHTS 2). Solicitors who do not come from a mental health law background are perceived as more likely to provide a poor-quality service (GM 1 LM 1). Less experienced solicitors were associated with providing clients with the least benefit (LM 1). Some solicitors were described as prolonging proceedings and influencing patients to appeal the tribunal ruling to make further income thereby seeming to not act in the best interests of the patient (GM 1 LM 4 MHTS 2). This was perceived as causing unnecessary distress, and creating false hope, leading to disappointment when the tribunal outcome does not reflect patient preferences (GM 1 MHTS 1). Some participants highlighted conflict arising when a named person was represented by a solicitor when the patient opts out of legal representation (Adv1) and suggested that the presence of solicitors in the tribunal increased the level of formality (Adv1).

“*Well, I was very pleasant, and I didn't take a dislike to anyone although I feel that my solicitor should have spoken up more. I mean, he didn't know me from Adam, he’d only met me five minutes before the tribunal.” -* Patient 9

Conversely, six patients reported positive experiences with legal representatives. Two individuals described a supportive and respectful long-term relationship with their lawyer who provided information, guidance, and helped them to present a positive view of themselves at the tribunal. One individual explained that their solicitor extensively explained the tribunal process to them and has continued to argue their case at tribunals for more than a decade.

The majority of named persons expressed frustration with solicitors while the minority reported satisfaction. Some named persons, who requested legal representation for themselves, were told by solicitors that they would not receive representation as they didn't have a sufficiently convincing case to present (2). In contrast to the majority view, four named persons reported positive experiences of legal representation at the tribunal hearing. Representation described as best practice included spending time with the patient before the tribunal (2); instructing an independent medical report (1); building a case and presenting evidence (2); and questioning and challenging evidence (1). Three patient participants explained that their advocacy worker helped them to arrange a solicitor and one patient received a list of solicitor names and contact details in the post with their tribunal reports.

3.2.5. (b) Curator Ad Litem role

The MHTS may appoint a *curator ad litem*[23] to safeguard the interests of a patient who lacks capacity to nominate a named person or are unable to instruct a solicitor. The *Curator ad litem* represents them at the tribunal hearing.

MHTS panel participants discussed the role of the curator, highlighting that the role of the curator is to act in the patient's best interests by providing independent evidence based on their legal assessment (MHTS 1). Panel members presented a positive view of the role of curators at the tribunal hearings. Several participants felt that the use of curators should be expanded to provide support for some patients who are currently considered to have capacity to instruct a solicitor (MM 1 LM 1). One participant indicated that the threshold for patient capacity to instruct a solicitor is too low, and many patients fail to adequately instruct their solicitor and would benefit from having a curator assigned instead (LM 1). One MHO suggested that both solicitors and curators are crucial for upholding patients' rights. One medical member participant suggested that curators are viewed as experienced and qualified advocates who may be more reliable in representing patients. It was highlighted by one tribunal panel participant that the curator role sometimes finishes too early, specifically when a recorded matter continues to exist after an order has been made, and the curator has completed their role (MHTS 1).

A solicitor, who also acts as a curator, explained their experiences of the role. They felt that proceedings run quite smoothly, and explained that, during their last case, they met with their client three times over three days before representing them at the hearing.

Two named person participants spoke about curators, one of whom had personal experience of working with one and the other in a professional capacity. The former expressed strong dissatisfaction with the representation stating that the curator was

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[23] Mental Health tribunal for Scotland (Practice and Procedure) (no.2) Rules 2005, rule 55.

ineffective and impeded participation. The other named person compared solicitors and curators and suggested that curators are often more effective in representing patients as they present more robust approaches and lines of arguments to the panel.

3.2.6. The Tribunal process and environment

3.2.6. (a) Adjournments, challenging evidence, length of proceedings and directions

There was limited conversation amongst MHTS panel members on adjournment of hearings with the overall view that a hearing is only adjourned when necessary because doing so means a patient's detention is continued by default. Reasons given for adjourning a hearing included situations where neither a patient nor any representation attend the hearing, and when a community patient leaves whilst the hearing is underway.

Health and social care professionals discussed the length of proceedings and directions. One MHO said that they used to be protracted, potentially spanning six to seven hours, but now they tend not to be so long owing to professionals' improving expertise (MHO 2). On the other hand, another MHO pointed out that hearings were often brief, some lasting ten to fifteen minutes, resulting in a lack of thorough discussion. Independent advocates discussed the MHTS panel's powers in helping patients who are waiting for services or accommodation. One argued that tribunal 'directions'[24] are distinct from recorded matters (Adv1) and that they can and ought to be used to influence patient care and treatment for their benefit (Adv3). While one named person and one patient said that the hearing was too brief, the opposite was the case for another two participants who explained that the tribunal was protracted, lasting for more than three hours with the same questions being repeatedly asked. However, one named person described the tribunal as thoroughly evaluating all evidence and described the panel as respectful and 'very human'.

Health and social care professionals provided mixed views on the appropriateness of the panel cross examining the evidence they present. One RMO suggested that the panel challenging evidence, and this being responded to, is indicative of evidence being thoroughly evaluated. It was said that MHOs are often not required to give much evidence (MHO 2) with the RMO usually providing the most evidence (Adv 1). MHO evidence was seen as mostly concerning the influence that social work has had over a person's circumstances over the years (MHO 1). Whilst one MHO felt that questioning is appropriate provided the environment does not become hostile as a result, another (MHO2) felt that excessive questioning of their evidence was inappropriate. One solicitor felt that the tribunal panel often ask the RMO or MHO

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[24] Mental Health Tribunal for Scotland (Practice and Procedure) (N0.2) Rules 2005, Rule 49.

presenting the evidence robust questions on the care plan, which can be very helpful to the patient as it forces the practitioner to explain the reasons behind their decisions.

3.2.6. (b) Support post-tribunal decision

Patient participants discussed the support that was available to them after the tribunal decision had been made. Six participants reported that they were not given any or sufficient professional support to process the decision. One described the difficult emotional process of struggling to cope with the outcome alone with no professional input or support. This was perceived as a particular issue for individuals living in the community. However, one person felt very positively about the amount of support they and their named person received, while others mentioned that they had received support from their solicitor (1), an independent advocate (1) or family (1) to process the tribunal outcome.

Named persons discussed the level of support available and the importance of carer's organisations. Five participants agreed that there was no support provided during or after the hearing while three explained that they independently discovered a carer's organisation which provided support. Two explained that a nurse provided support for the patient who was upset during the tribunal. Five participants felt that more support for carers is necessary.

3.2.6. (c) Physical environment

Many participants commented on the physical environments and location of the tribunal hearings. Some tribunal hearing venues were viewed as a barrier to enabling patient and named person involvement, however improvement in some areas were reported and welcomed (LM 1). MHTS panel members also mentioned that when MHTS hearings are held outside hospitals in the community patients are not provided with adequate support compared with hospital patients who are supported by a nurse when attending their hearing (MHTS 2).

One solicitor explained that, while most hospital venues are adequate, in certain locations they feel that they are *'bunged in a cupboard in the back of beyond in some admin block'.* Unsuitable venues made some patients feel that the tribunal hearing was an afterthought (Adv 1).

Seven patients provided positive or neutral views on the hearing venue and environment whilst six provided more negative views on these. Three experienced a tribunal hearing venue as somewhat confrontational with the patient's team on one side, and professionals on the other and a considerable distance between them. One described the venue as institutional and clinical, three as it being small and cramped, another as non-descript and minimalist and another as uncomfortable. Four patients expressed unhappiness about the hearing taking place in the same building as their ward. One went on to explain the proximity added to the impression that the tribunal's decision was weighted towards RMO opinion, and another felt that having the hearing at the hospital was not neutral. Venue security was perceived by one participant as excessive, leaving them feeling scrutinised. Another commented on the shared waiting room, feeling that patients and their representatives should have a separate area.

3.2.7. Tribunal decision making

Participants also discussed the factors which contribute to a decision being made at the MHTS panel and the way in which the decisions are communicated.

3.2.7. (a) The process of making and communicating decisions

The MHTS panel's decision is usually communicated verbally to the patient at the end of the hearing. A full decision is then provided in a detailed FFR. Some MHTS panel participants highlighted the comprehensive detail contained in FFR reports (LM 1 MM1 GM 1). Some participants raised the issue of access by the MHTS panel to previous FFRs to inform decision-making. One MHTS panel participant detailed how in their experience previous FFRs were not always made available. Others, however, recounted receiving the FFRs from the previous two tribunals hearings (MHTS 1) or receiving the result from the original order application (MHTS 2). Some participants felt that it is important for all FFR information to be shared (MHTS 2).

When health and social care professional participants discussed the FFR report some participants suggested further detail behind the decision was required (MHO 3). One MHO stated that in their experience the decisions do not always specifically refer to the principles of the Act in the FFR (MHO 1). On the other hand, a RMO participant said that in their experience the FFR was carefully considered and detailed, and a solicitor participant highlighted that the least restrictive option is set out in the FFR report (S2).

A named person participant also mentioned that in their experience the FFR was somewhat limited.

"I think as far as I can remember, it was relatively limited, I think it was - we've heard and our view is - that they're in agreement with the application being made and although it's not information or the decision would have not gone in my wife's wishes, their view was that she needed to remain in hospital." – Named Person 8

Independent medical reports can be introduced to the panel by named persons to provide them with an alternative medical viewpoint to that of the patient's RMO. The use of independent medical reports was a further salient point related to tribunal decision making. Panel members focused on one concern in particular; that a patient's solicitor can decide to withhold independent medical reports (MHTS 1). However, it was highlighted that the independent report is instructed by the patient's solicitor on behalf of the client and they decide whether it is submitted as part of the evidence (LM 1).

There was some discussion amongst health and social care professionals on the tribunal panel deliberations during decision-making. Some highlighted that panel members often do this over a period of a few minutes which was perceived as too short to make a fully informed decision. Participants spoke of occasions where some tribunal panels do not adjourn the hearing to deliberate their decision. This was perceived by one solicitor participant as 'ridiculous' and one RMO highlighted that this can be perceived by a patient as a 'slam dunk' since there was no real consideration of their options and they had little chance to influence the outcome. One MHO suggested that sometimes the panel may adjourn when no real deliberation is necessary to give the patient the impression that more deliberation and consideration has taken place. The importance of the constitution of individual panel members was highlighted by one RMO who spoke about how difficult it can be for three people, who potentially do not know each other, to reach an important decision together or to disagree with each other. In contrast, another RMO said that the three different disciplines comprising the tribunal panel in fact complement each other and aid the decision-making process (RMO 1).

3.2.7. (b) Information used to inform decision making

In discussions amongst health and social care professionals, the five criteria were seen to be the focus of the panel members, whilst considering the Millan Principles appeared to be a secondary consideration (RMO 2 MHO 2). Some participants highlighted that the principles should be given more prominence at the hearing compared with the five criteria (MHO 2). Two named person participants highlighted that some tribunal panels appeared to view their role as testing the five criteria and any further evidence gathering and testing during a hearing as outside of their role boundaries. One solicitor participant stated that a MHTS panel that focused more on the five criteria as legal 'tests' could restrict informed decision making (S1). An independent advocate participant stated that MHTS panel decision making is necessarily limited due to the boundaries of the legislation and their role and suggested that the legislation should be reviewed and amended to provide them with more scope regarding care and treatment decisions.

There was some discussion on whether risk factors are over-represented at hearings. For example, one person considered a patient's risk assessment based on offending history from 25 years prior without any recent evidence of offending as an over-exaggerating risk. However, some MHTS panel participants stressed that offending history and all related background information are relevant to the tribunal decision (MHTS 1 MHTS 6) whether the person offends at present or not (MHTS 1). Panel members must look back at historical offences and judge the person's behaviour when they were not receiving treatment for their mental disorder, as the person may return to behaving in this way if their order was revoked and their treatment stopped (MHTS 2). The severity of the offence committed is very important when making this decision (MHTS 3). Some MHTS panel members also highlighted that the aim of the panel is to protect patients and so they are by default risk averse (LM 1 MHTS 1).

When health and social care professional participants discussed the perception of risk at the tribunal and the use of historical evidence, one MHO felt that risk processing was seen as vital in ensuring the tribunal provides a patient with benefit and they are protected from harm (MHO 1). One solicitor participant, however, said that the MHTS panels are perceived as very conservative decision makers, especially so in the case of children and young persons(S1).

One patient recounted that they felt that risk was exaggerated by the clinical team and this heavily influenced the panel. Four named person participants also said that they felt that that risk is over-exaggerated by the panel and one said that historic offences committed by the patient can be greatly exaggerated in tribunal paperwork.

Health and social care professional participants discussed the impact that care plans can have on MHTS panel decision making. Detailed care plans were necessary for the panel to make informed decisions regarding the granting of specific kinds of orders, such as Community Compulsory Treatment Orders (Adv2). It was highlighted that if care plans lacked detail then it may impact on tribunal panel decision making and in some circumstances could result in an adjournment, thereby potentially impacting on the outcome for a patient (S1). Some participants stated that an inadequate care plan may lead to a tribunal hearing resulting in an interim order or rejecting a community order application. Others suggested that further training for RMOs on writing care plans might help to improve their content and assist panel members in their decision making.

3.2.7. (c) Recorded matters

'Recorded matters' are treatments, care or services which the MHTS considers essential to an individual's care (for example, medical treatment, community care services, children's services, psychological support and addiction services) which are specified in a CTO when made[25]. Whilst recorded matters are particularly important in the case of community-based orders they may also be applicable where

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[25] Section 64(4)(a) Mental Health Act; Mental Health Act *Code of Practice*, Volume 2, para 3.91.

a person is detained in hospital. RMOs and the Mental Welfare Commission may report services which the patient does not receive which are a recorded matter[26].

Recorded matters were discussed by some MHTS panel participants as an available approach to address specific needs of patients. However, it was noted that recorded matters can remain unresolved (MHTS 1 Adv1). Some participants highlighted that it is within their role to use recorded matters to make the Tribunal and health and social care service providers aware of barriers impacting on the provision of appropriate care and treatment. Some participants were of the view that recorded matters were a good idea but had little or no impact because they lacked real 'teeth' as there is no real consequence for not complying.

'The challenge for us is that often the services that they would need don't exist' - MHTS 3

Other MHTS panel and health and social care professional participants were of the view that in some cases recorded matters had resulted in a service director or manager being required to attend a tribunal hearing and provide evidence of the actions taken to address the issues identified (MHTS 1 MHO 2 Adv 1). Other participants highlighted that the availability of resources to meet needs is often at the heart of the making of a recorded matter, and some said that community resources were something of a 'postcode lottery', with patients' geographical location perceived as impacting on the services available.

3.3 Developing MHTS systems and processes

As part of the data collection process, participants offered a range of ways that, based on their experience of the MHTS, its systems and process could be further developed. These included:

a) MHTS panel members should always visit patients on their hospital ward if they were unable to attend their hearing.
b) Reviewing the status and position of recorded matters and place a legal duty on compliance.
c) Establishing a mechanism by which to raise general issues that arise during hearings that are not a recorded matter.
d) Providing patients with RMO and MHO intended evidence in a written format prior to the hearing to enable them to prepare fully with their solicitor and correct inaccuracies.
e) Providing simple hospitality at hearings for patients and named persons such as tea and coffee and more comfortable seating, and a separate waiting area for named persons.

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[26] Sections 96(3) and 98 Mental Health Act.

f) Access to independent advocacy for named persons to provide information and support before, during and after the tribunal hearing.
g) Reinstating the use of feedback forms to be completed at the end of a hearing which had been put in place during the Covid-19 pandemic with a view to sharing examples of best practice and issues of concern.
h) The development of independent resources and information regarding the Mental Health Act and the tribunal process for patients, named persons, and families.
i) A review of the Mental Health Act to ensure that it reflects the CRPD position on compulsory detention and treatment.
j) Further training and development opportunities for MHTS panel members, including:
   i. How to ensure that the views of patient and their named person are more fully and accurately presented in the FFR.
   ii. How and when in the hearing process to involve the patient in the hearing from the outset.
   iii. How to ensure that patients and their named person fully understand the purpose of the hearing and the order being requested and the restrictions that may be imposed consequently.
   iv. How to enable a named person to provide evidence that opposes the patient’s wishes appropriately within the hearing.
   v. How the MHTS panel can more fully scrutinise care plan proposals and the service delivered to ensure reciprocity is a reality for patients.

k) Specific training and development for solicitors representing patients and named persons on mental health conditions, their treatment and management and services and supports provided in hospital and communities.

Chapter Four: Discussion, conclusions and actions

4.1. Discussion

The primary objective of this study was to identify views and experiences of how the MHTS processes and decision-making operate in terms of adherence to the Mental Health Act and international human rights principles and where improvements may be made. This chapter discusses the findings and draws some conclusions from the data and wider research literature. It ends with recommendations for action relating to improvements for such processes and decision-making.

This study has been undertaken against the backdrop of a number of challenges for the MHTS and its role in safeguarding and implementing the Mental Health Act principles and patients' rights. These challenges include the emphasis on the autonomy increasingly promoted by ECHR case law and particularly seen in the CRPD 'paradigm shift' in approaches to the rights of persons with mental disorder, international attention over the role of mental health tribunals, steadily rising levels of psychiatric compulsion in Scotland and the Scott Review. They additionally include the transfer of the MHTS from its standalone status to that of a chamber within the First-Tier Tribunal for Scotland in the Scottish Tribunals framework. Finally, recommendations, if realised, from a recent review of the delivery of forensic mental health service in Scotland (Independent Forensic Mental Health Review, 2021) and proposals for a Scottish national care service (Scottish Government, 2021b) may also impact indirectly or directly on MHTS service delivery.

The consequences of the Covid-19 pandemic, of course, also impacted on this study and the MHTS. It both affected recruitment of participants to the study and also brought the safeguarding role of the MHTS into sharper relief. The real test of a state's commitment to fulfilling its human rights obligations is during times of emergencies, including pandemics (Stavert and McKay, 2020). Some of the study data was collected prior to the Covid-19 pandemic and related restrictions occurring across health and social care in Scotland, and we did not specifically gather data on how the MHTS operated during the pandemic. However, we had the benefit of a survey undertaken by the MHTS of views about the telephone hearings put in place during the pandemic (MHTS, 2021).

Our primary objective was to collect data from a purposive sample of stakeholders involved in the MHTS process. Whilst our participant numbers did not meet the original anticipated sample, we are nevertheless satisfied that we identified the main recurring themes and issues. We have also been able to compare this, to further ensure consistency, with published information from the Scott Review, Vox Scotland and the Mental Welfare Commission for Scotland.

This study has been about the views and experiences of stakeholders and has not been to determine statutory or human rights compliance in individual cases. The Mental Health Act allows for compulsory psychiatric care and treatment. We recognise that patients who are subject to MHTS processes are there because they are either deemed unable or are unwilling to consent to care and treatment for mental disorder and that such processes and their outcomes are likely to be distressing and unwanted. This may undoubtedly influence the perception of most, if not all, patients of such processes and the outcomes certainly at the time if not later. However, the real test of the effectiveness of human rights standards is not only whether they are given effect by state authorities, such as tribunals, it is the extent to which they are felt to be given effect by rightsholders. In this case, patients who are subject to MHTS processes. If steps can therefore be taken to reinforce existing good practice and reduce approaches and practices that cause or exacerbate the distress of patients and their families, then such compliance is more likely to be felt.

We encountered a great deal of caring goodwill and a determination to give effect to the Mental Health Act principles and rights of patients on the part of MHTS panel members and health and social care professional participants. This was accompanied by reflection on what worked well and where improvement is perceived as necessary. Patient and named person participants were equally reflective although generally more critical of the MHTS processes as a consequence of their experiences. There were several areas of agreement across all participant groups as well as certain areas where the experience of patients and MHTS panel members was not shared. Key themes which we identified are set out below.

4.1.1. Human Rights and the MHTS process

At present, the MHTS must perform its role under the Mental Health Act in accordance with the patient's ECHR rights and, to the extent that this is currently possible within the existing legal framework in Scotland, their CRPD rights. Whilst reference to specific human rights was rare across the participant groups, there was a general feeling that these are enshrined in the Mental Health Act's principles and practices. Moreover, any reference to rights tended to be in ECHR terms which is not surprising given that these influenced the development of the Millan Principles. The limited reference to CRPD rights is likely to reflect the fact that these rights are not yet fully reflected in the legislation[27] although some health and social care professionals did comment that they were aware that the current system is one of substitute decision-making which raises issues of incompatibility with Article 12 CRPD and that there should be a greater emphasis on, and guidance requiring, supporting the decision-making of patients rather than simply implementing substitute decision-making. However, whilst it is unlikely that Scotland will completely abandon laws authorising non-consensual psychiatric treatment (Scott Review,

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[27] See Chapter One for a more detailed discussion on this.

2022), the general direction of travel requiring greater adherence to the CRPD will require the MHTS to adhere to the treaty's requirements, particularly in terms of recognising non-discriminatory enjoyment of rights, supporting decision-making and autonomy, seeking alternatives to psychiatric coercion, and the right to health and independent living. This will be required in relation to the interpretation of existing and any future mental health law in terms of giving effect to its underpinning principles and criteria for compulsory measures.

4.1.2. Specific Millan principles issues

Particular issues in relation to each of the Millan principles were identified by the study participants.

4.1.2. (a) Non-discrimination, equality and respect for diversity

Information obtained during the study suggests more needs to be done to ensure that adjustments or accommodations are made to ensure greater consistency and availability of support for persons with hearing impairments, non-native English speakers, communication challenges and physical disabilities, noting the duties in this regard in the Equality Act 2010 and state duties in the CRPD. Additionally, issues arose regarding the general level of awareness and understanding relating to black, Asian and minority ethnic patients, religious practices and references to gender. This builds on the observations and recommendations of the Rome Review relating to equality and persons with learning disabilities and autism.

4.1.2. (b) Benefit, informal care, least restrictive alternative and reciprocity

The principles of benefit, informal care and the least restrictive alternative are underpinned by the rights to autonomy and liberty[28] and to physical and mental integrity[29] as well as the highest attainable standard of physical and mental health[30] and independent living and participation in society[31]. Whilst these were all generally regarded as fundamental principles, perceptions as to the extent to which they were implemented differed between the participant groups. Some of the differences arose over the interpretation of what constitutes benefit but resourcing challenges across health and social care services were also often seen as impacting on the full implementation of these principles. Moreover, the reciprocity principle is integral to the realisation of the rights that underpin the benefit principle and it was generally agreed by all participants that a lack of resourcing makes it a difficult principle to give effect leading to inadequate service provision, notably in terms of community options and potentially least restrictive measures. This mirrors evidence provided to the

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[28] Articles 8 and 5 ECHR; Articles 12 and 14 CRPD).

[29] Article 8 ECHR; Article 17 CRPD

[30] Article 25 CRPD; Article 12 International Covenant on Economic Social and Cultural Rights.

[31] Article 19 CRPD.

Scott Review which indicated that limited resources in the community lead to the deterioration in mental illness, and patients expressed that inadequate care and treatment provided in the community often leads to avoidable mental health crises making compulsory measures less necessary (Scott Review, 2020).

4.1.2. (c) Participation

Article 8 ECHR case law reinforces the need for respect for a patient's views concerning their care and treatment. Article 12 CRPD goes further than this in that it requires that the will and preferences of the patient must always be determinative on the same basis as they are for others, and not simply be one of a number of competing factors in care and treatment decisions.

All participant groups did indicate that they regarded that there was some level of patient participation at hearings yet there were also a number of obstacles to this. MHTS panel members largely tended to stress the importance of patient participation but several patients, named persons and health and social care professionals participants spoke of tokenistic participation at hearings with patient views often being perceived to be discounted, no attempt being made to ascertain the views of non-attending named persons and the outcome of the hearings appearing a foregone conclusion. The role of the MHTS panel convenor was seen as pivotal in promoting effective patient participation at hearings. The order of speaking at hearings and formality and complex language use were also highlighted as potential and actual impediments to participation. This all appears to coincide with evidence from other jurisdictions which demonstrate that while tribunals are often intended as an avenue for patient involvement with significant participatory potential, meaningful participation is often limited in practice (MacGregor et al., 2019).

4.1.2. (c)(i) Supporting participation and the exercise of legal capacity

There was some discussion among the participants about what amounts to support for the exercise of legal capacity (supported decision-making) and adjustments or accommodations to overcome decision-making challenges and communicate views in these circumstances. This included measures such as rescheduling hearings where necessary, the use of less legalistic, sometimes simplified, language, adopting a less formal approach, and visiting patients on wards instead of requiring them to attend. Across the participant groups it was widely agreed that this is good practice although not necessarily consistently followed. Independent advocacy and advance statements, both recognised by the Mental Health Act[32] were also mentioned by participants. While it was thought that these can be of benefit in supporting the voice of the patient, they were perceived as currently being somewhat limited. This was particularly felt in terms of the availability and sometimes quality of advocacy, and

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[32] Sections 259-259A and 275-276C Mental Health Act.

uptake of advance statements and reference to them in hearings. This is supported by other reviews which have also noted inadequate resourcing of independent advocacy in mental health in Scotland and other countries (Scott review, 2020; MacGregor, Brown and Stavert, 2019) and the fact that this has meant that it tends to be focused on compulsory treatment situations in Scotland (Scottish Independent Advocacy Alliance, 2017; Mental Welfare Commission for Scotland, 2018).

4.1.2. (d) Child welfare

In terms of the child welfare principle MHTS panel members and health and social care professionals appreciated that a child's needs, the impact of compulsion on them and potential parental influence raised issues. However, there is possibly misunderstanding by some panel members over the child welfare principle in section 2 of the Mental Health Act who believed it to apply to a patient's children (with child protection issues potentially being an issue) rather than, as it should, a child or young person patient.

4.1.3. Wider issues relating to hearings

All participants also raised wider additional issues relating to MHTS hearings which include and go beyond specific Millan principles, relating to MHTS hearings.

MHTS panel members in particular mentioned tensions around the use of certain types of information. Sufficient information to allow for the robust consideration of evidence and information is required and, in some cases, this might be distressing and humiliating for the patient. Some also wondered whether the now shorter hearings and fewer interim and adjourned hearings might impact on the evaluation of evidence, whilst some health and social care professionals, named persons and patient participants also expressed concern over the apparent limited time taken by the panels to make their decision, given the magnitude of the issues involved. Across all the participant groups it was also recognised and appreciated that the tribunal hearing process was generally a distressing one for patients which could, amongst other things, be humiliating and invoke or increase feelings of helplessness, as well as impacting on their relationships with professionals and family members.

MHTS panel members also generally indicated that considering risk is very important but health and social care professionals, whilst seeing risk and benefit as interrelated, noted, along with some named person participants, that clinical teams tend to be risk averse and this tends to influence the MHTS panel. This accords with the findings of the systematic review undertaken as part of this study that demonstrated that stakeholders across jurisdictions often feel that risk is overestimated and taken out of context at tribunals (MacGregor et al., 2019).

MHTS panel members frequently spoke of their frustration over recorded matters being very difficult to enforce thus resulting in these rarely being made or sought by RMOs. They also said that whilst recorded matters have the potential to operationalise the provision of services, resource limitations often mean that certain services are simply not available. At the same time it was suggested that there should also be a specific avenue allowing for raising questions about the fulfilment of care, support and treatment issues which fall short of recorded matters. The current shortcomings of recorded matters is an issue which has also been noted by the Scott Review. It has consulted on its suggestion that the MHTS's power should be strengthened to require that the NHS, local authorities and integration authorities provide such clinically justified care and support as may be required to avoid the need for compulsion and ensure that any compulsion respects the whole range of a patient's human rights. These rights include economic, social and cultural rights which, if legally enforceable, are particularly relevant to ensuring the fulfilment of recorded matters (SMHLR, 2022).

The importance of the manner of communication of the outcome of a hearing was also made clear with the content, clarity and accuracy of the Full Findings and Reasons Report and any oral communication being integral to this.

The fact that there tends to be less support for patients at hearings held in community settings, as opposed to those held in hospitals, was also mentioned, while in general participants felt there was limited support to help a patient process the outcome of a hearing after it has taken place.

4.1.4. Perceptions of fairness and the power of the medical domain

A patient's perception of the fairness of a hearing might inevitably and understandably correlate with its outcome. As stated, it was not this study's role to determine the lawfulness of such outcomes and it was important to identify specific aspects of the process which may be perceived as fair or unfair by all the participants. Patient concerns about the fairness of MHTS's processes will inevitably have implications for how its role in ensuring the right to a fair trial (Article 6 ECHR) and access to justice (Article 13 CRPD) is perceived. It also impacts on patients' right to dignity (Article 3 ECHR and Article 15 CRPD) to liberty (Article 5 ECHR and Article 14 CRPD), and the respect for private and family life (autonomy) (Article 8 ECHR).

The issue of whether the hearings are perceived to be conducted fairly was raised by all participant groups. MHTS panel members tended to comment that they believed that patients' perceptions of fairness were influenced by the extent to which they were able to participate in the hearing. This also appeared to be borne out by the named person and patient participants. Some named person and patient participants also, however, expressed concerns about the presentation, and sometimes accuracy, of evidence supplied as well as unequal weighting of the parties' evidence, with greater weight being afforded to professional evidence.

A particularly dominant feature was the perceived power imbalance in favour of medical professionals. Across the health and social care professionals and named person and patient groups the weight given to RMO evidence was noted. Some MHTS panel members also admitted that RMO evidence is rarely challenged by the panel and that the medical panel members tend to set the tone with general members not feeling their opinions carried as much weight. The convenor's role was regarded as integral in preventing this power inequality. This reflects evidence also collected by the Scott Review (Scott Review, 2020) and the study's systematic literature review which found similar experiences across other jurisdictions, highlighting concern about mental health tribunals' lack of scrutiny of medical evidence and the high percentage of tribunal outcomes that align with medical viewpoints (MacGregor et al., 2019).

4.1.5. Support for patients at hearings

Supported decision-making and wider support to aid participation in MHTS hearings, including, amongst other things, independent advocacy and advance statements, have been detailed above. However, additional issues arose in relation to named persons and legal representation.

The need for greater clarity and support for named persons was highlighted. Some named person participants felt that they were unclear about their role or rights and expressed concern about the adequacy of the information they received from the MHTS, reflecting the same view expressed elsewhere (Scott Review, 2020, 2022). A particular example of the role being misunderstood was illustrated where some named person participants stated that independent advocacy was unnecessary for a patient where a named person is nominated. These roles are different. Independent advocates stand alongside and support the patient to navigate the mental health system, including the MHTS, and may speak for the patient (Scottish Independent Advocacy Alliance, 2019). They do not have rights to apply and make appeals to the MHTS. A named person's role, on the other hand, is to look after the interests of a patient and MHTS application and appeal rights and can appear and be represented at hearings (although named person participants felt that legal representation was not easy to access particularly where they were challenging treatment decisions). However, they may advance their own views, as opposed to those of the patient, about the patient's care and treatment and have these considered (Scottish Government, 2019b).

Whilst introduced with a view to respecting a patient's right to choice and privacy,[33] the removal of the 'default' named person provision by the Mental Health (Scotland) Act 2015 for patients aged 16 years and older was generally seen by MHTS panel members and health and social care professional participants as leaving some patients, where they do not have the capacity, to nominate a named person without support. Moreover, the 'listed initiators' process was seen as an inadequate substitute for the named person role.

The importance of effective legal representation for the patient to protect their rights was a generally held view. However, there were mixed views amongst the participants about the quality of and approach taken by solicitors before the tribunal. This issue does not, however, appear to be confined to the MHTS and is evident regarding mental health tribunals in other jurisdictions (MacGregor et al., 2019). More widely, we are aware of challenges concerning accessibility, in terms of the availability of solicitors with appropriate expertise and funding, but these issues were not explored in any detail by the participants.

Again, across the participant groups, there were mixed views and knowledge about *curators ad litem*. However, as these are appointed without the patient's consent, issues concerning patient autonomy of choice and supported decision-making to allow the exercise of that choice, particularly considering CRPD requirements, should be reflected here.

4.2. Conclusion

The MHTS is under a statutory obligation to give effect to the rights-based principles underpinning the Mental Health Act in its processes and decision-making. Information gathered during this research study indicates that MHTS panel members are acutely aware of this and the ECHR implications. They will also have to take full account of CRPD requirements particularly in terms of equality in rights enjoyment, alternatives to compulsory psychiatric care and treatment and supported decision-making. This is a requirement immediately and going forward.

The data highlighted the frustrations of MHTS panel members caused by wider resourcing issues within the health and social care systems which sometimes weakened their ability to give full effect to these principles. The study findings from health and social care professionals, patients and named persons identified areas of good practice relating to MHTS processes and decision-making. However, concerns were identified, despite the best efforts of MHTS panel members, namely relating to patient participation, and support for this, and perceptions of power and influence of clinicians, both appearing to influence perceptions of fairness. Other areas in particular requiring further attention relate to the role and support of named persons

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[33] Article 8 ECHR (right to respect for private and family life).

and carers and representation. We, of course, only gained the views of a sample of persons with experience of the MHTS processes and decision-making, and children and young persons and persons living with dementia were not included within the sample. However, the views and experiences of those with experience of the MHTS processes and decision-making are in accord with and more widely supported by Scott Review and other evidence. The identified issues are not confined to the MHTS and have been noted in other jurisdictions (Macgregor et al., 2019).

The researchers recognise that MHTS cannot address all the issues identified by patients, named persons and health and social care professionals. It is important to differentiate the issues within the immediate responsibility of the MHTS and those that are not, and those that rest with the Scottish Government, clinicians, lawyers NHS Boards and local authorities, and those requiring legislative change. These issues are reflected in the evidence-informed actions we recommend which also take into account the areas for change made by study participants set out in Chapter 3.

4.3. Recommendations for action

4.3.1. Recommendations for action within the remit of MHTS

The MHTS should:

1. Review the CRPD requirements of non-discrimination, alternatives to non-consensual psychiatric care and treatment and supported decision-making which can enhance the implementation of the Millan Principles and reflect this in its decision-making.
2. Identify where imbalances of power, particularly in relation to the clinical/medical domain, may be perceived by patients to occur and actively seek to address this.
3. Identify obstacles to patient participation in their hearings and put in place measures to address them.
4. Ensure that named persons have the opportunity to access independent advocacy and legal representation before, during and after the tribunal hearing.
5. Review the processes and practices to ensure that named persons are provided opportunities to provide their views either in person or in writing at a hearing.
6. Review the processes and practices to ensure that the views of patient and their named person are fully and accurately presented in Full Findings and Reasons reports.
7. Review the processes and practices to ensure that patients and their named person have access to information regarding the hearing and the order being requested and the potential outcomes.

8. Review the processes and practices to enable the effective scrutiny of care plan proposals and the service delivered to promote reciprocity for patients.
9. Consider the different characteristics highlighted on section 1(3)(h) of the Mental Health Act[34] and effect reasonable adjustments and accommodations in order to ensure equality of rights enjoyment in MHTS processes and decision-making.
10. Establish further training and development opportunities for MHTS panel members in to address the developments required in processes and practices that pro-actively involve patients, their families and named persons in this.

4.3.2. Recommendations for action outside the remit of the MHTS

To be included in the Scott Review final report recommendations and be reflected by the Scottish Government in subsequent legislative and policy reforms:

11. The reinforcement of the CRPD requirements outlined above in legislation.
12. The review of the status and position of recorded matters by placing a statutory enforceable duty on NHS Boards and local authorities for compliance.
13. Establish a statutory mechanism to raise, monitor and respond to general issues other than recorded matters arising during MHTS processes and hearings.
14. Evaluation of existing and alternative measures for supporting participation in the MHTS processes by patients and named persons, including the role of advance statements.
15. Review the role of named persons and the availability of legal representation.
16. Review the role and efficacy of *curators ad litem*.
17. A statutory duty on clinical teams to consider alternatives to compulsory psychiatric care and treatment.

The Scottish Government should ensure:

18. Adequate resourcing of community-based services and support for persons with mental disorder.
19. The development of easily accessible independent resources and information regarding the Mental Health Act and the MHTS process for patients, named persons, and families.
20. Increased resourcing for independent advocacy.
21. The commissioning of research that explores the experiences of children and young persons and persons living with dementia of MHTS processes and decision-making.

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[34] In other words, 'the patient's abilities, background and characteristics, including, without prejudice to that generality, the patient's age, sex, sexual orientation, religious persuasion, racial origin, cultural and linguistic background and membership of any ethnic group.'

The Scottish Government should require and the Law Society of Scotland should ensure:

22. Training for solicitors representing patients and named persons on common mental health conditions and care, support and treatment in hospital and communities and related ECHR and CRPD requirements.

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Appendix A

Sections 1 and 2 Mental Health (Care and Treatment) (Scotland) Act 2003

Section 1: Principles for discharging certain functions

(1) Subsections (2) to (4) below apply whenever a person who does not fall within subsection (7) below is discharging a function by virtue of this Act in relation to a patient who has attained the age of 18 years.

(2) In discharging the function the person shall, subject to subsection (9) below, have regard to the matters mentioned in subsection (3) below in so far as they are relevant to the function being discharged.

(3) The matters referred to in subsection (2) above are—

(a) the present and past wishes and feelings of the patient which are relevant to the discharge of the function;

(b) the views of—

(i) the patient's named person;

(ii)any carer of the patient;

(iii) any guardian of the patient; and

(iv) any welfare attorney of the patient,

which are relevant to the discharge of the function;

(c) the importance of the patient participating as fully as possible in the discharge of the function;

(d) the importance of providing such information and support to the patient as is necessary to enable the patient to participate in accordance with paragraph (c) above;

(e) the range of options available in the patient's case;

(f) the importance of providing the maximum benefit to the patient;

(g) the need to ensure that, unless it can be shown that it is justified in the circumstances, the patient is not treated in a way that is less favourable than the way in which a person who is not a patient might be treated in a comparable situation;

(h) the patient's abilities, background and characteristics, including, without prejudice to that generality, the patient's age, sex, sexual orientation, religious persuasion, racial origin, cultural and linguistic background and membership of any ethnic group.

(4) After having regard to—

(a) the matters mentioned in subsection (3) above;

(b) if subsections (5) and (6) below apply, the matters mentioned there; and

(c) such other matters as are relevant in the circumstances,

the person shall discharge the function in the manner that appears to the person to be the manner that involves the minimum restriction on the freedom of the patient that is necessary in the circumstances.

(5) Whenever a person who does not fall within subsection (7) below is discharging a function by virtue of this Act (other than the making of a decision about medical treatment) in relation to a patient, the person shall have regard, in so far as it is reasonable and practicable to do so, to—

(a)the needs and circumstances of any carer of the patient which are relevant to the discharge of the function and of which the person is aware; and

(b)the importance of providing such information to any carer of the patient as might assist the carer to care for the patient.

(6) Whenever a person who does not fall within subsection (7) below is discharging a function by virtue of this Act in relation to a person who is, or has been, subject to—

(a) detention in hospital authorised by a certificate granted under section 36(1) of this Act (any such certificate being referred to in this Act as an “emergency detention certificate”);

(b) detention in hospital authorised by a certificate granted under section 44(1) of this Act (any such certificate being referred to in this Act as a “short-term detention certificate”);

(c) an order made under section 64(4)(a) of this Act (any such order being referred to in this Act as a “compulsory treatment order”); or

(d) an order made under [F1section 57(2)(a) or 57A(2)] of the 1995 Act (any such order being referred to in this Act as a “compulsion order”),

the person who is discharging the function shall have regard to the importance of the provision of appropriate services to the person who is, or has been, subject to the certificate or order concerned (including, without prejudice to that generality, the provision of continuing care when the person is no longer subject to the certificate or order).

(7) A person falls within this subsection if the person is discharging the function by virtue of being—

(a) the patient;

(b) the patient’s named person;

(c) the patient’s primary carer;

(d) a person providing independent advocacy services to the patient under section 259 of this Act;

(e) the patient’s legal representative;

(f) a curator *ad litem* appointed by the Tribunal in respect of the patient;

(g) a guardian of the patient; or

(h) a welfare attorney of the patient.

(8) In subsection (3)(a) above, the reference to wishes and feelings of the patient is a reference to those wishes and feelings in so far as they can be ascertained by any means of communication, whether human or by mechanical aid (whether of an interpretative nature or otherwise), appropriate to the patient.

(9) The person need not have regard to the views of a person mentioned in subsection (3)(b) above in so far as it is unreasonable or impracticable to do so.

(10) In subsection (3)(d) above, the reference to information is to information in the form that is mostly likely to be understood by the patient.

(11) In this section, a reference to “discharging”, in relation to a power, includes a reference to exercising the power by taking no action; and “discharge” shall be construed accordingly.

Section 2: Welfare of the child

(1) This section applies whenever a person who does not fall within section 1(7) of this Act is discharging a function, by virtue of this Act, to which subsection (2) or (3) below applies in relation to a patient who is under the age of 18 years.

(2) This subsection applies to any duty which may be discharged in more than one manner.

(3) This subsection applies to any power.

(4) The person shall discharge the function in the manner that appears to the person to be the manner that best secures the welfare of the patient.

(5) In determining the manner of discharging the function that best secures the welfare of the patient, the person shall have regard to—

(a) the matters mentioned in section 1(3) of this Act;

(b) the matters mentioned in section 1(5) and (6) of this Act (where those subsections apply); and

(c) the importance of the function being discharged in the manner that appears to the person to be the manner that involves the minimum restriction on the freedom of the patient that is necessary in the circumstances.

(6) Subsections (8) to (10) of section 1 of this Act shall apply for the purpose of subsection (5)(a) above as they apply in relation to subsection (3) of that section.

(7) In this section, a reference to “discharging”, in relation to a power, includes a reference to exercising the power by taking no action; and “discharge” shall be construed accordingly.

Appendix B

Applications which can be made to the Mental Health Tribunal for Scotland under the Mental Health (Care and Treatment) (Scotland) Act 2003

Section 50 – an appeal by the individual or named person against a STDC
Section 63 – an application for a CTO
Section 92 – an application to extend and vary a CTO
Section 95 – an application to vary a CTO
Section 100 – an appeal by the individual or named person
Section 189 – reference by the Scottish ministers where an individual is subject to a CORO
Section 192 – application by the individual or named person where the individual is subject to a CORO