Are Mental Health Tribunals A Good Use Of Money?

In the ongoing process of examining the review of the Mental Health (Care and Treatment) Act 2003, the question of Compulsory Treatment Order has come up.

Some people with learning disabilities have expressed concerns to us about the role psychiatrists play in making determination about the treatment of people with learning disabilities and that tribunals do not give them the right support. .

Mental Health Tribunals were set up in 2003 to provide a specialist check on the use of Compulsory Treatment Orders. The service costs almost £9 million per year with Tribunal members being paid about £400 per day when sitting.

Yet from our research it appears that less than 2% of applications for Compulsory Treatment Orders are refused. Other research based on a Randomised Control Study from England has suggested that Compulsory Treatment Orders are no more effective at helping people get better than the previous legislative provisions for compulsion in medical treatment.[1]

What do Mental Health Tribunals do?

The main role of the Tribunal is to consider and determine applications for compulsory treatment orders (CTOs) under the 2003 Act. It also considers appeals against compulsory measures such as short term detention certificates and compulsory treatment orders. The Tribunal also reviews every compulsory treatment order once it has been in place for two years and every two years after that.

Each Tribunal meeting has a group of three people - a doctor (psychiatrist), a lawyer and another general member, that is a person with relevant skills and experience, e.g. a nurse, social worker or someone with personal experience of mental illness, learning disability or related condition.

Initial Concerns about bias

When the Tribunal were set up there were some concerns that they would be biased towards the views of the psychiatrist. It was said that many of the "general members" were Community Psychiatric Nurses and more likely to give more weight to the psychiatrist. The Legal Member who chairs the meeting might make sure the formalities were carried out properly but would not have any medical experience to challenge the view of the responsible psychiatrist.

The evidence that the tribunal hears comes from either a Mental Health Officer (normally a social worker) or the Responsible Medical Officer (who can often be another psychiatrist).

The domination of psychiatry in the process led to worries that the patient would not be in a strong position to challenge the use of Compulsory Treatment.[2]

These worries were challenged at the time as unevidenced and unsupported. All members of a Tribunal come with their own views and have different approaches. All parties to the tribunal system have a "discipline-based approach" reflecting their own training and experience. The point

[1] http://www.nhs.uk/news/2013/04April/Pages/community-treatment-orders-psychiatric-readmissions.aspx
[2] The Journal of the Law Society of Scotland, http://www.journalonline.co.uk/Magazine/50-11/1002425.aspx

of a Tribunal is to bring together these approaches into a vigorous consideration of the evidence and come to the conclusion that is in the "best interests" of the patient. [3]

Other safeguards

The other part of the tribunal are the safeguards that are part of the process. Named Persons, Advance Statements, Legal Representation and Advocacy. These were designed to make sure that there was consideration of the views of the patient. MHTS are often singled out as an example of good practice in terms of user involvement. There are a range of tribunals across Scotland, and the Mental Health Tribunals are placed at the top end for service user good practice.

But there are problems with the number of "Named Persons". Many people have never nominated one. The same with Advance Statements.

Section 259 of the Act provides every person with a mental disorder with the right of access to independent advocacy. This can empower individuals by assisting them to articulate their views on issues affecting them in situations which they may find unfamiliar and stressful is an important safeguard, assisting in keeping the focus firmly on the patient in the Tribunals.

Advocates are not at Tribunals to express a particular view. Instead their job is to help the patient be involved in any relevant decision making process and to get as much information as they can to make informed choices before, during and after tribunals.

Views of Service Users

However research by Julie Ridley in 2013 which looked at interviews of service users who had been through the tribunal process found that while they were listened to more it had not challenged the dominance of psychiatry in the process.

> Consensus was that although service users felt there was increased opportunity for their voices to be heard, this was not matched by having increased influence over professional decision-making, especially in relation to drug treatments. According to people's direct experiences, the passing of the legislation in itself had done little to change the dominant psychiatric paradigm.[4]

In 2011, the People First Grand Jury heard evidence about the difficulty that people with learning disabilities had in challenging such orders. It is difficult to prove that people will be safe in the community if they are not in the community in the first place.

> "My lawyer says I need an independent psychiatrist's report to say I won't hurt anyone. I got one but he said he couldn't say I would never hurt someone. I never hurt anyone in the last 29 years but he said that might be because I never had the chance to do it."[5]

As result the Grand Jury concluded;

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[3] The Journal of the Law Society of Scotland, http://www.journalonline.co.uk/Magazine/51-4/1002922.aspx

[4] Ridley, J. and Hunter, S. (2013), Subjective experiences of compulsory treatment from a qualitative study of early implementation of the Mental Health (Care & Treatment) (Scotland) Act 2003. Health Soc Care Community, 21: 509–518. doi:10.1111/hsc.12041

[5] http://www.gov.scot/Resource/0040/00408057.pdf - p36

We were also worried that Mental Health Tribunals too often simply agree with the medical opinions that are given to them. While the Jury welcomed the Commission's suggestion that Tribunals give people their say at a much earlier stage, we felt this did not go far enough in helping people challenge medical opinion.[6]

The Results from Mental Health Tribunals

The Mental Welfare Commission reports that in 2014-15 there were 1,259 new compulsory treatment orders during the year. This was an increase of over 7% on previous years.

At LDAS we were interested to see how many applications for Compulsory Treatment Order were turned down. That would help to indicate the degree that service user's voices were heard. It is important to note that all parties may agree that a CTO is in the best interest of a service user but it must still go in front of a Tribunal.

Emergency Detention and Short Term Detention are two ways of delivering compulsory treatment quickly but are very time limited. Any treatments of longer than 28 days would have to go to a tribunal.

While neither the Mental Health Tribunal Scotland Service does not publish statistics on the outcomes from tribunals, they do publish the outcomes of each hearing along with the Mental Health Action section that the hearing was called under. That does allow for some statistics to be produced and we have drawn the following table from these hearing results for the first 8 months of this year.

Outcomes from Mental Health Tribunal held in Scotland for Jan-Aug 2016				
Section	Brief Description	Total	Granted	Refused
63	Application for Compulsory Treatment Order	1378	1321 (98.2%)	24 (1.8%)
95 101 (2b) 161 149 92 158	All Applications to vary or extend CTOs	497	434 (96.2%)	17 (3.8%)
			Order Confirmed	Order Revoked
50	Revocation of short term detention	375	288 (90%)	32 (10%)
100 (2a)	Revocation of Compulsory Treatment Order	209	139 (90.8%)	14 (9.2%)

The discrepancy between total and the outcomes in due to hearing being adjourned, applications being withdrawn or incomplete data in a number of hearings.

We need to be careful in interpreting this data. MHTs are aiming for the best interests of people who may not be in a position to judge for themselves what that is. Many of them will lack capacity to make decisions. So we cannot assume that they would not have agreed to this treatment if they had been able to make the choice.

The two rows of data dealing with Revocation of Short Term Detention and Compulsory Treatment Orders we can be more sure of. All of these were brought in challenge to existing decisions. Only 10% of decisions were in favour of the patient. It would seem clear that there is a degree of concern

[6] http://www.gov.scot/Resource/0040/00408057.pdf - 939.

amongst those subject to compulsory treatment and that few are able to successfully challenge the grounds for compulsion.

How Has This Changed Over Time

We looked at the Mental Health Tribunal results for the first 8 months of 2008 to see if the results had changed over time. These were the earliest statistics for the same time period available.

Outcomes from Mental Health Tribunal held in Scotland for Jan-Aug 2008				
Section	Brief Description	Total	Granted	Refused
63	Application for Compulsory Treatment Order	1378	1293 (97.7%)	30 (2.3%)
95 101 (2b) 161 149 92 158	All Applications to vary or extend CTOs	674	528 (95.5%)	25 (4.5%)
			Order Confirmed	Order Revoked
50	Revocation of short term detention	171	122 (88.4%)	16 11.6%)
100 (2a)	Revocation of Compulsory Treatment Order	16	8 (100%)	0 (0%)

These results display a remarkable consistency over the time examined. Over an 8 year period only about 2% of all application for Compulsory Treatment Order are refused by the tribunals. And only 4% of all applications to extend or vary a CTO were refused.

There does seem to a growing attempt by patients to use Section 100 (2) (a) to have a Compulsory Treatment Order overturned but it is not within our remit to explain why this is.

Our Conclusions

Overall we can say that the Mental Health Tribunal supported the decisions of the Psychiatrists and Mental Health Officers and there may show some evidence that there is a leaning towards the mental health professionals and their dominance in the decision making process.

At the Learning Disability Alliance Scotland we have been worried about reports of people with learning disabilities being kept in hospital or subject to other decisions at the hands of psychiatrists. We believe that if it is hard for the more able people subject to compulsory treatment to challenge decisions that affect them, then it will be much harder for people with learning disabilities.

At the Cross Party Group for Learning Disability in September 2016, we heard a story about a non verbal young man with learning disabilities and autism kept in hospital and regularly restrained. He regularly entered the main living area to pick at the wall and wall paper until he had removed the clock from the wall. At that point, the staff would restrain him and return the clock to the wall. The problem to the nursing and medical staff was the behaviour of this young man/ It was not until the lay inspectors visited that anyone thought that the loud ticking of the clock might be the problem. When the clock was removed, the young man's behaviour changed.

If highly trained staff are unable to interpret what appears to be very clear non verbal communication of such patients in such minor matters, how will their views ever be taken into

account in respect of their wider treatment? There is a point when “discipline based approach” needs to be balanced by the views of patients and service users.

We do think there is merit in further investigation into the outcomes of Mental Health Tribunals in Scotland especially given the review of the Mental Health (Care and Treatment) Act that is being undertaken by the government.

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