An Exploration of the Early Operation of the Mental Health Tribunal for Scotland
AN EXPLORATION OF THE EARLY OPERATION OF THE MENTAL HEALTH TRIBUNAL FOR SCOTLAND

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The views expressed in this report are those of the researcher and do not necessarily represent those of the Scottish Government or Scottish Ministers.
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EXECUTIVE SUMMARY

Background
The Mental Health (Care and Treatment) (Scotland) Act 2003 (MHSA) established the Mental Health Tribunal for Scotland (MHTS) as an independent body which replaced the Sheriff Court as the forum to consider decisions about the compulsory care and treatment of those with mental health problems. A review of the operation of the MHSA is currently underway. In light of concerns about the type of disposals - particularly the number of interim orders - arising from MHTS hearings, the review is examining both the efficiency and quality of the processes for civil orders.

Aims
The study had two broad aims:

- To explore the detailed operation of the MHTS with a specific focus on processes that are perceived to have increased the number of interim orders and multiple hearings.
- To make recommendations for the future development of processes related to the making of civil orders in the MHSA, which will inform the review of the MHSA 2003.

Methods
The research comprised:

- Analysis and review of MHTS monitoring data
- Collation and analysis of costs associated with MHTS operations (administrative, local authority, health board and legal)
- Case studies in three local authority areas with in-depth face to face or telephone interviews with 14 key informants and five immediate post-Hearing group discussions with Panel Members
- A System Mapping Workshop, facilitated by an expert team of consultants from the London School of Economics which brought together key players in the MHTS.

Main findings

The operation and impact of the MHTS in practice

- The number of CTO applications received between October 2005 and December 2007 was over 3,500 which resulted in approximately 5,700 hearings\(^1\)
- In over 50% of cases, more than one hearing was required to make a full decision on each application

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\(^1\) The data management systems used at MHTS were developed to administer the Tribunal and not as a monitoring tool to provide accurate and easy to access statistical data and this hampered secondary data analysis and limited what and how data could be used
There was consensus that the new system had improved patients’ experiences, and reflected the guiding principles in relation to fairness, patient focus and participation. Concerns were raised that the system may impact negatively on the therapeutic relationship if medical carers support the need for a CTO that the patient disputes and may also be upsetting for patients. Some venues were deemed inappropriate, affording no private space for families and patients to meet with their lawyer. The format and mechanisms for processing of data collected for administrative purposes by MHTS and Local Authorities and Health Boards may inhibit useful analyses.

**The input and impact of the range of participants who may be involved in each MHTS hearing**

- The participation of the range of people other than panel members who may be required (or may wish) to attend a hearing can be compromised by the short notice of some hearings.

**The processes involved in making a civil order under MHSA which may be contributing towards the high level of interim orders and multiple hearings.**

- While there was a view that the number of interim orders was too high, this was seen – in part –as an inevitable consequence of the new patient-centred system.
- The main reasons cited for the high number of iCTOs were the need to appoint a Curator Ad Litem (an issue which has since been resolved) and requests for an Independent Medical Report (IMR).
- It may not be possible to conduct an IMR in advance of the hearing due to insufficient time and/or a lack of psychiatrists in a position to conduct the review.
- There were some concerns that an IMR may be requested as a delaying tactic, for financial gain.

**External factors which may be affecting the efficacy or efficiency of MHTS processes.**

- Electronic submission of applications was inhibited by a lack of awareness of this facility and also by technical difficulties associated with electronic submission.
- The administrative processes may also be hampered by the late arrival of CTO applications within the 28 day STDO period, leaving little time to fulfil the MHSA stipulation for hearings to be convened with 5 days of a STDO expiring.

**The costs of the MHTS system, in total and on an individual case and hearing basis.**

- The total audited costs for MHTS-related activity in 2006-07 are estimated at £12,784,909. This includes all MHTS administration costs, SLAB costs and known costs associated for the time of RMOs, MHOs and medical records staff.
• MHTS Administration costs accounted for £8,301,000, with Panel Members’ fees accounting for more than 50% of the total
• Many of the costs incurred by local authorities and health boards relating to mental health tribunals are subsumed within existing budgets and, therefore, it was not possible to provide any accurate figures for how much they spend on tribunal related activities
• Local authorities currently receive an annual grant of £13 million to improve mental health services as part of implementing the MHSA 2003. The precise allocation of these funds is not known and cannot be attributed to defined areas of work (be they capital or recurrent)
• The average cost per hearing is estimated at £3,774. However, this does not include grants to local authorities and means that our estimates are likely to be an under-representation of the true costs.

Recommendations

The recommendations are drawn from the research exercise and also from the System Mapping Event which was attended by a range of participants involved in MHTS and its operations.

Improving systems for monitoring and audit

• Ensure that the data are processed in a format that allows statistical analysis of key variables in relation to information that is not currently accessible in a format for statistical analysis, such as diagnosis
• If a more informed picture of health board and local authority costs are required, there is a need to develop systems for recording time and costs associated with Tribunals.

Improving systems for the submission and processing of CTO applications

• Revision of the application form to make it more user-friendly and to avoid repetition
• Improve mechanisms for submission, so that applications can be submitted by email, ensuring that all relevant parties are aware that they can submit electronically
• Pre-tribunal preparation and screening by MHTS to facilitate earlier identification of errors or omissions, or the need for a Curator Ad Litem, legal representation and an independent medical report
• Consider whether variations to CTO need to be heard at a hearing or whether that can they be dealt with more efficiency by paper
• Where an appeal is lodged against a CTO, the papers from the original application should be made available to the appeal Tribunal. The report for that hearing should then describe the case history since the last hearing/ decision.
• The appointment of the Curator Ad Litem before the first hearing could reduce the number of interim orders and reduce costs, time and effort, but requires a decision about who has the financial responsibility for the appointment.
Dealing with the consequences of the legal / evidential nature of the tribunals

Consider ways in which the possible negative impact on the therapeutic relationship of legal requirements to cross examine might be minimised, including:

- Avoidance of repeated oral hearings in which the reasons for a patient’s detention are reiterated
- Replace RMOs’ full reports with a brief statement indicating that each of the 5 criteria have been met. (The RMO is present for the hearing and so could elaborate if necessary)
- Consider whether all patients coming to Tribunal should routinely have an independent medical opinion. The increase in efficiency and reduction in interim treatment orders would more than compensate for the increased report-writing.

Training and capacity

Some of the actors in the MHTS process may contribute to delays or confusion because they do not fully understand the law or complete the forms as intended. There is a need, in the first instance to:

- Review the training that is available and its take-up, both for those coming new to the process and as a ‘refresher’
- Consider ways in which understanding the roles and perspectives of other participants might be facilitated
- Improve understanding of the role of the Named Person
- Increase number of MHOs, particularly in geographically widespread areas; and political commitment to organise and pay for out-of-hours MHO cover
- Address the real deficit, particularly in rural areas, in the number of lawyers skilled and enthusiastic to represent clients at Tribunals and psychiatrists to conduct IMRs
- There is a need to encourage a greater number of lawyers to undertake mental health work and to provide training as part of that process
- Increase efforts to recruit and train more members of the public, service users and carers to be panel members.

The Act and MHTS

Finally in relation to the terms of the Act itself and its administration:

- Increase the duration of the STDO 42 days to allow improvements to patients’ response to treatment to become manifest
- Consider extending the five day period of grace to give the administration more time to process the application and organise a hearing, and therefore, address the problems associated with the current short notice for hearings
- Merge the MHTS with all Scottish tribunals into one body. This could enhance staff opportunities, venues could be shared and therefore be closer to where people live, and better use would be made of clerk and clerk assistant time.
CHAPTER ONE  INTRODUCTION

1.1 The Mental Health (Care and Treatment) (Scotland) Act 2003 (MHSA) was an important reform of mental health law in Scotland. The Act was informed by the range of professionals and others involved in mental health care, including health care professionals, policy makers, service planners, carers and service users. The Mental Health Tribunal for Scotland (MHTS), an independent body, was put in place and replaced the Sheriff Court as the forum to consider decisions about the compulsory care and treatment of those with mental health problems and represents one of the fundamental changes to the mechanisms for applying Mental Health Law in Scotland.

1.2 A review of the operation of the MHSA is currently underway. In light of concerns about the decisions arising from MHTS hearings, the review is examining both the efficiency and quality of the processes for civil orders. In particular, as the research brief describes, concerns relating particularly to multiple hearings, interim orders, and the nature of the participation of parties in the process require exploration. The review is intended to lead to more streamlined and simpler processes which, in turn, would result in fewer hearings and a more satisfactory experience for patients and clinicians. This research reported here was commissioned in order to inform the review by exploring the early operation of MHTS.

Mental Health (Scotland) Act 2003: key elements

1.3 The Mental Health (Scotland) Act 2003 (MHSA) provides a comprehensive revision of the legal framework for compulsory detention and treatment of those with mental disorders. The new act sets out the roles, responsibilities and principles underpinning the legislation, the compulsory powers for detention and treatment, and the rights and responsibilities of patients and service providers alike.

1.4 Underlying the Act are a set of guiding principles that reflect the recommendations of the Millan Committee (2001). These are intended to enshrine the basic rights of all those with mental disorders and, fundamentally, set the tone for the ways in which care is delivered. The new Act creates a series of “certificates” that determine in what situations, by whom, and with what conditions compulsory care can be invoked. The Act also codifies the rights of people with mental disorders to advocacy, support and redress through the newly established Mental Health Tribunal Scotland (MHTS) and extends the remit of the Mental Welfare Commission to monitor the working of the Act.

1.5 The Act also defines a set of specific professional roles – Mental Health Officers (MHOs), Responsible Medical Officers (RMOs), and Nurses 'of the prescribed class' – each of whom has distinct functions in relation to the Act.

1.6 Most importantly, the Act establishes that people with mental disorders must retain their basic rights and responsibilities and should not be subject to discrimination on the grounds of social position (e.g. age, gender, sexual orientation, and ethnicity). Moreover, care should be delivered in ways that respect individual diversity. It is assumed that, wherever possible, care and treatment should be provided without recourse to compulsory powers. However, where care is imposed on an individual, local authority and health care services
have a reciprocal obligation to provide safe and appropriate services and, while respecting
their own and others need for safety, to do so in ways that are “in the least restrictive manner
and to be of benefit the service users”. Insofar as it is possible, service users should be
enabled to participate in decisions relating to all aspects of their care and their wishes should
be taken into account. The rights, needs and experience of carers are also to be
acknowledged, and the welfare of children with mental disorders are deemed paramount.

1.7 The Act therefore creates a set of procedures, roles and responsibilities that, taken
together, represent a significant shift in the ways in which mental health care and,
particularly, compulsory detention and treatment is delivered. In turn, these changes are
likely to affect the experiences of mental health patients, their carers and the professionals
and organisations delivering care.2

The Mental Health Tribunal Service

1.8 The creation of the Mental Health Tribunal for Scotland (MHTS) is one of the
fundamental changes to the mechanisms for applying Mental Health Law in Scotland. As
mentioned previously the MHTS replaced the Sheriff Court as the forum to consider
applications for civil compulsion and all appeals against compulsion.

1.9 The MHTS is made up of two distinct areas: the Administration, based at the
Hamilton Headquarters staffed by 80 Scottish Government civil servants, and the Tribunal
which is an independent Non-Departmental Public Body (NDPB), headed by a President.

1.10 The Administration process all applications, appeals and revocations regarding
compulsory orders. Individual caseworkers record and process applications, invite
participants to hearings, handle paperwork, and coordinate tribunal hearings. The scheduling
team assist in coordinating attendance of panel members at the hearing venue and Hearings
Clerks assist on the day of the hearing.

1.11 The independent tribunals, convened across Scotland, are responsible for hearing and
making decisions on the long term compulsory care and treatment of people with mental
health disorders. Each three-member tribunal panel comprises a legal member (convenor), a
medical member (psychiatrist) and a general member3 drawn from a pool of some 300 panel
members, each appointed for five years on a part-time basis.

1.12 A number of other people can be involved with someone whose case is brought
before the Tribunal and may be present at a tribunal hearing, e.g.: the patient; the named
person; the patient’s carer; the patient’s guardian; the patient’s solicitor; the Mental Health
Officer; Responsible Medical Officer (RMO); Medical practitioner; Welfare Attorney;
Curator Ad Litem; and any other person with an interest.

3 Clear criteria specify who a general member may be and includes people with experience of mental health or a
qualification in social care, e.g: service users; carers; nurses; psychologists; social workers; occupational
therapists; care service workers; and managers.
1.13 The powers of the Tribunal in determining an application are to:

- grant it
- refuse it
- grant an interim Order for a shorter period
- vary measures
- add new measures

1.14 This research was primarily concerned with the processes and procedures involved in the granting of compulsory treatment orders (CTOs) and interim compulsory treatment orders (iCTOs) by the Tribunals. Compulsory powers concerning offenders with mental disorder were not the focus of this research and have, therefore, not been included.
CHAPTER TWO RESEARCH AIMS AND OBJECTIVES

Aims and objectives

2.1 The aims of the research were to:

- Explore the detailed operation of the MHTS with specific focus on processes that are perceived to have increased the numbers of interim orders and multiple hearings.
- Assess the views of key stakeholders including: tribunal panel members; Hearing Clerks, patient representatives; and service professionals on these processes, the way in which the MHTS works in practice and the role of participants engaged within MHTS hearings.
- On the basis of findings and in consultation with the Scottish Government’s Research Advisory Group, make recommendations for the future development of processes related to the making of civil orders in the context of MHSA, and to inform the limited review of the MHSA 2003.

2.2 The specific objectives of the study were:

- To identify and describe the operation and impact of the MHTS in practice from the perspectives of all relevant stakeholder groups.
- To investigate the input and impact of the range of participants who may be involved in each MHTS hearing and to highlight any relevant issues in relation to their participation.
- To examine in detail the processes involved in making a civil order under MHSA which may be contributing towards the high level of interim orders and multiple hearings.
- To identify external factors which may be affecting the efficacy or efficiency of MHTS processes.
- To explore the costs of the MHTS system, in total and on an individual case and hearing basis.
- To provide recommendations on: ways in which processes for the making of civil orders may be streamlined to reduce the incidence of multiple hearings and interim orders; means of addressing external factors which impact on the efficiency of MHTS processes, and the appropriate range of participants and issues identified in relation to their role in MHTS hearings.
CHAPTER THREE  RESEARCH DESIGN AND METHODS

Summary of the research

3.1 The study was conducted in three case study areas: Glasgow, Edinburgh and Highland and the following three stage research design was used.

Stage One – An exploration of the operation of MHTS

- Analysis of aggregate data from MHTS case management and Webroster system
- In-depth interviews with MHTS stakeholders
- Small group discussions with Tribunal panel members

Stage Two – Whole System Approach to identify barriers and improvements

- Multi-Disciplinary Design Workshop with 5 – 6 stakeholders
- System Mapping Workshop

Stage Three – Identification of the costs of MHTS

- MHTS HQ administration and Tribunal panel costs
- Patient representation (including legal aid) costs
- Health board and local authority costs

Research access and ethics

3.2 The research study underwent full ethical review by NatCen’s Research Ethics Committee. A copy of the proposal was also submitted to the National Research Ethics Service (NRES) and the Scottish Multi Research and Development Review (SMRDR) to establish whether the research required full review by these bodies. It was deemed that the study did not require full review. Access to local authority employees (e.g. MHOs) in Edinburgh and Glasgow (but not Highland) required submission of, local research access questionnaires. Access was approved.
Stage One – An exploration of the operation of MHTS

3.3 The aim of the first stage of the study was to gain an understanding of the ways in which the MHTS processes and procedures are operating in practice, within the context of the principles underpinning the Act. The overall objectives were: to identify barriers to the MHTS operation; the main reason for granting of interim orders, and the subsequent impacts on the system.

A three strand approach was adopted, consisting of:

- analysis of routine monitoring data collected by MHTS relating to case processing and hearings
- in-depth interviews with key informants
- small group discussions with panel members, immediately post hearing.

Each is discussed in more detail below.

Analysis of MHTS case processing and hearings data

3.4 The aim of this element of the study was two-fold. First, to assess the usefulness of the data collected and held by MHTS and, second, to provide secondary analysis of the data so that patterns relating to case processing and hearings (which might throw light on barriers within the system) could be identified.

3.5 Databases used by MHTS were not designed to collect and record data for research or monitoring purposes, but to allow effective administration of the Mental Health Tribunal process and, inevitably, this affected what analyses could be carried out and should be borne in mind when we discuss some of the barriers to effective use of the data.

3.6 The MHTS hold two separate databases - the Case Management System (CMS) and Webroster. The Case Management System stores information from application forms and all paperwork relating to a case. The system was developed during 2004/2005 by external system developers and an on-going support agreement was put in place. The system went live on 05 October 2005, but incremental development has taken place since. Standard reports are produced from this system, some of which are included in the quarterly statistics published on the MHTS website, but ad-hoc reports can also be produced on request.

3.7 The Webroster is the scheduling system used to find suitable dates for each Tribunal Hearing and to allocate correct resources to each – for example, panel members, hearing clerks etc. It is an ‘off-the-shelf’, rather than a bespoke, system which is hosted externally with a copy of the database sent to MHTS weekly.

3.8 After discussion with MHTS Data Analyst and IT manager, we produced a document outlining the data we required. The main source of the data was the Case Management System. Further discussion clarified the full range of data that could be extracted from the system. After this meeting, a full list of data requests was submitted to MHTS (see Appendix A).
3.9 MHTS provided password protected data (within 61 separate Excel spreadsheets), including aggregated and disaggregated data, ad-hoc reports and data from standard reports. The Excel files contained data relating to the following categories:

- Applications
- Short-Term Detention Orders
- Hearings
- Attendees at hearings
- Outcome of hearings (e.g. no. of CTOs and iCTOs granted)
- Timescales
- Venues

3.10 Initial inspection indicated that there were some discrepancies between files relating to the total number of cases and patients. The Excel files were checked by exporting data into SPSS (statistical data software) and merging several files together to create one master file. After further discussion with the MHTS, discrepancies appear to be due to:

- Missing data relating to specific variables – for example, gender.
- Repeated case numbers – for example, the same case number may appear more than once if there were multiple hearings for one case.
- Different time periods for application and hearings data – for example, applications submitted before 31st December 2007 appear in the application analysis, but do not appear in the hearing data tables, unless the first hearing took place before the cut off date for the study.

3.11 The data used within this report have, wherever possible, been verified and clarified. This was largely only possible for disaggregated data which included fields that existed in other files. Some aggregated data are contained within this report, but we are not able to check its reliability (see paragraphs 4.7 to 4.10 for more information on data quality issues).

In-depth interviews with Tribunal key informants

3.12 In-depth interviews with 14 key informants were conducted. Informants were either key participants to the Tribunals in each of the case study areas or people with a national perspective of, or involvement in, the MHTS. Where possible, interviews were conducted face-to-face. All participants were given an information leaflet to read and informed consent was obtained. (See Appendix G).

3.13 The key informant categories were defined in consultation with the Research Advisory Group. Potential informants were identified via the advisory group, but also via the MHTS administration, Social Work Managers, and via interviews and small group discussions (snowballing).

3.14 Almost all legal representation of patients in the Highland area is carried out by just two main law firms, neither of which is based in the region. Despite numerous attempts to elicit the participation of lawyers within these firms, it was not possible to include lawyers representing patients in Highland.
3.15 Table 3.1 shows the distribution of key informant interviews for this element of the study.

Table 3.1 Key informant interviews by area and interview mode

<table>
<thead>
<tr>
<th>Informant</th>
<th>Area 1 City</th>
<th>Glasgow City</th>
<th>Area 2 Edinburgh City</th>
<th>Area 3 Highland</th>
<th>National perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal representative</td>
<td>Telephone</td>
<td>Face to face</td>
<td>Unsuccessful</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Mental Health Officer</td>
<td>Telephone</td>
<td>Telephone</td>
<td>Face to face</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Advocacy representative</td>
<td>Face to face</td>
<td>Face to face</td>
<td>Face to face</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Responsible Medical Officer</td>
<td>Telephone</td>
<td>Telephone</td>
<td>Unsuccessful</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Mental Welfare Commission</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Face to face</td>
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</tr>
<tr>
<td>British Medical Association</td>
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<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Telephone</td>
</tr>
<tr>
<td>Law Society</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Face to face</td>
<td>Face to face</td>
</tr>
<tr>
<td>MHTS</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Face to face</td>
<td>Face to face</td>
</tr>
</tbody>
</table>

3.16 The topic guides for interviews with key informants (see Appendices B & C) covered the following areas:

- Involvement in the MHTS and what impact (if any) their involvement had on other work
- Perceptions of the hearing process, e.g. the amount of notice given for a hearing, time to prepare and read the paperwork, and appropriateness of the venue
- Perceptions of the number of interim order granted, reason why there are so many and ideas to reduce them
- Perceptions of the efficiency of the MHTS and how this can be improved.
Small group discussions with Tribunal panels

3.17 Mini group discussions with panel members were held directly after a hearing. This allowed the research team to capitalise on the fact that panel members were already together and would, therefore, be more likely to participate. More importantly, this approach allowed reflection of an actual case while still fresh in panellists’ minds.

3.18 Before specific panels were approached, a letter was sent to all panel members telling them about the study and alerting them to the possibility that they may be asked to give their views through a mini group discussion. We were supported by the MHTS administration staff who notified us of hearing dates and informed Hearing Clerks that the research team would be conducting the post-hearing discussion groups.

3.19 A total of six mini groups (two in each case study area) were proposed and, despite initial scepticism on the part of some stakeholders about the willingness of panel members to stay behind after a hearing, five of the six proposed groups were conducted. Unfortunately, one planned group discussion in Highland could not be conducted, as members wished to leave to travel home.

3.20 Similar issues to the stakeholder interviews were discussed, but the focus was on the case they had just heard (see Appendix D). Like stakeholder interviews, panel members were given an information leaflet and informed consent was obtained before the discussion started.

Analysis

3.21 Interviews and mini groups were digitally recorded and transcribed verbatim. Transcripts were analysed using “Framework”, a method developed by the Qualitative Research Unit at NatCen. Framework is a systematic and transparent method of analysis that ensures thorough and comprehensive treatment of the data and reliability in interpreting findings. Using is a matrix-based approach to analysis, ‘Framework’ is a means to synthesise and condense verbatim transcripts. It treats cases consistently and allows within, and between, case investigation.

3.22 The first stage of analysis involved familiarisation with the transcribed data and identification of emerging issues which helped develop a thematic framework. A thematic framework is a series of thematic charts, each representing one key theme. The column headings on each chart relate to key sub-topics, and the rows to individual respondents. Data from each case is them summarised in the relevant cell. The context of the information is retained and the page of the transcript it came from noted so it is possible to return to a transcript and explore a point in more detail or extract text for verbatim quotation. These thematic charts allow for the full range of views and experiences to be compared and contrasted both across and within cases, and for patterns and themes to be identified and explored (an example chart is appended).
Stage Two – Whole System Approach

3.23 This stage of the work was led by an expert team of consultants with a wealth of experience in conducting various forms of action research in the public sector: Julian Pratt, Pat Gordon and Diane Plamping of PPG Consultancy.

3.24 ‘Whole System Working’ is one of a spectrum of action research approaches which can be used to bring participants in a system together. It differs from the traditional research approach used in stage one – where researchers extracted information from existing data and stakeholders – by actively bringing together key players in the MHTS and enabling them to learn more about the system they are working in and to improve the part they play in its operation.

3.25 Crucially, the whole system approach offered people involved in the MHTS an opportunity to see how the system works from different perspectives, to understand the knock-on consequence of their own actions and to collectively come up with possible improvements to the current service. Thus, the whole systems approach was both a ‘diagnostic’ tool, which enabled a better understanding of the way the MHTS operates, but was also an intervention in its own right – i.e. it had the potential to create immediate change in working practice.

3.26 In practice the whole system approach worked via a ‘system mapping’ event (held in June 2008). Through lively discussion of a typical CTO case, a map was created which unravelled the complexities faced by all within the MHTS system (see appendix H for a photograph of the map). This then led on to discussion of how the MHTS system, in relation to CTOs, might be improved.

3.27 The success of the system mapping event was entirely dependent on ensuring a range of relevant stakeholders involved in the MHTS were present. This was crucial to illustrate the complexity of the MHTS process and the varying roles people have within it. Around 100 people involved with the MHTS were notified of the forthcoming workshop, of which 54 agreed to attend. On the day 36 participants attended and included:

- Named Persons
- Advocacy Workers
- MHOs
- Solicitors
- Psychiatrists
- CPNs
- MHTS Administration staff
- Panel Members
- Mental Health Team Leaders & Managers
- Mental Health Act Review team members

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5 The improvement of public sector delivery: supporting evidence based practice through action research. Dr Cathy Sharp. Knowledge transfer: Scottish Executive Research: 2005
3.28 In order to prepare a typical CTO case (to develop the ‘system map’), six people, with a variety of roles in MHTS, were invited to take part in a half day design workshop prior to the mapping workshop. The aims of the design workshop were threefold: to explore problems encountered with the MHTS processes and what changes would make a difference; to identify the full range of appropriate participants for the mapping workshop; to develop a typical CTO case that was both credible and relevant.

3.29 As noted above, the purpose of the system mapping day was to explore ways the MHTS could be improved and record potential solutions to current problems. These recommendations have been used to help shape the recommendation chapter. Throughout the days notes were taken, by the project team, and have been incorporated into the body of the report where relevant (i.e. if they disagree with what has been said by stakeholders or introduce new findings).

3.30 In order to consolidate new learning from the system mapping event, all participants were sent a report of the day for their own reference, which is appended.

**Stage Three – Assessment of MHTS costs**

3.31 The purpose of this element of the research was to explore the range of costs associated with the MHTS process, which include:

- costs covered by MHTS Administration, e.g. clerical and administration costs; costs for panel members; costs for MHTS staff to run a hearing e.g. Hearing Clerks and Venue Assistants;
- legal representation costs for people detained under the act, using data from the Scottish Legal Aid Board (SLAB); and
- costs for local authorities and health board.

3.32 To inform this element of the research a total of 35 emails were sent along with several telephone calls to people who had either: taken part in an interview (or facilitated contacts for interview); participated in a focus group discussion; or attended the system mapping event. We asked them to think of costs associated with the MHTS process and the monetary value associated with these costs.
CHAPTER FOUR MHTS DATA

4.1 In order to obtain a better understanding of the work carried out by MHTS, we have conducted a secondary analysis of routine data collected by MHTS. This includes information relating to CTO applications, timescales, hearing venues, those who attend hearings, and CTO hearing outcomes. The MHTS database was not intended to be used for research purposes. This meant that information we as researchers might have found useful was either not available or not available in an appropriate format for our purposes. We describe some of the limitations this imposed on the research and the wider implications for the collection and collation of routine data by MHTS.

Data Held by MHTS Administration Office

4.2 The MHTS administer applications for different types of compulsory treatment and compulsion orders. However, not all applications and changes to orders require a Tribunal Hearing. Our focus is on the administration of Compulsory Treatment Order (CTO) applications and the route from application to the final outcome of a hearing.

Processing CTO Applications

4.3 The MHTS hold two separate databases; the Case Management System (CMS) and Webroster (see paragraphs 3.6 & 3.7).

4.4 When an application for a Compulsory Treatment Order is received at MHTS in Hamilton, it is input into the Case Management System (CMS), but not all the data are entered in the same way. Most of the information provided on the application form, which is a multiple choice selection, is data-entered into a field in the database. However, most of the free text, which includes details on personal circumstances of the patient and proposed treatment, is not entered on the database, apart from the names and addresses of key people - for example, the patient and the MHO. The free text is recorded when the complete application form is scanned to produce a PDF file, using a separate document management system called SharePoint. These documents can then be viewed via the CMS on a case by case basis. The same scanning procedure is used for all the additional paperwork which is attached to the application form - for example, the two medical reports. This means that the free text data are not in an easily accessible format for coding (and, hence, statistical analysis) or for extracting specific information.

Data Reporting and Quality

4.5 There are a range of standard reports which can be extracted using existing code and a limited selection of these reports, relating to the different orders dealt with by the MHTS, is presented in quarterly and annual reports available via the MHTS website. The full range of standard reports available is listed in the MHTS Data Reports Catalogue and these can be requested on an ad-hoc basis.
4.6 The management team at MHTS receive a weekly bulletin on key performance indicators relating to the progress of applications through to hearings. All staff members receive a separate weekly bulletin including data on applications, number of hearings and phone calls received. A more detailed monthly report is circulated to the management team and the Scottish Government.

4.7 The MHTS have acknowledged that there are concerns about the quality of the data extracted from the two database systems and used in their reports. The data requested for the purposes of this study were not easy to extract and unique complex code had to be written. The Audit Scotland Report 2006 stated that the provision of key statistics is an important component in the performance management system of MHTS\(^6\) and it is, therefore, important that all parties have confidence in the data collected, both in terms of completeness, relevance and accuracy. There are several reasons that have been suggested for a lack of confidence in the accuracy of the data produced.

4.8 First, the database was developed to administer the Tribunal process efficiently, by processing applications, setting up hearings, recording outcomes, and not as a monitoring tool. It had to be built on assumptions about how the Tribunal process was going to work. For example, when the system developers designed the database, it was set up to link only one hearing to the case record and all other hearings were archived. In practice, most cases have more than one hearing, which has caused difficulties in linking all the related hearings for one case together for statistical purposes. This can lead to inaccurate data being extracted because the link between a case and a hearing is missed, and therefore, the number of hearings per case may be under reported. The outcome of a hearing is recorded on a separate form which is linked to the application but is not linked to the details of the hearing, making it difficult to investigate which decision relates to which hearing.

4.9 Second, the programme to extract the standard reports was written by the original system developers and an external contractor in 2005, and some of the code was written incorrectly. MHTS staff have checked and amended some of these standard reports and plan to check all of the reports when possible.

4.10 Third, a unique Case Reference Number (CRN) is generated for every new application and used for all correspondence and data linkage. When the database was developed there was no data held at the patient level. However, an addition to the system means that each individual now has a Patient Identification Number (PIN). There are, nevertheless, concerns that the PIN is not always linked across multiple cases – that is, when there is more than one CTO application for a specific individual. Data are mostly stored in reference to the CRN and this reference number is therefore regarded as the more reliable. It should be noted that data produced using the CRN relate to the number of applications and hearings, not the number of different individuals involved.

4.11 There is information which, although recorded in the application form or in accompanying reports, cannot be easily extracted to produce data for monitoring purposes. This includes most of the free text and accompanying medical reports that are not data-entered but scanned into a PDF. While it is possible to search the PDF for key words, there is

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no standard language used, so different terminology may be used to describe similar factors rendering such an exercise both time-consuming and of suspect validity. This means that certain information cannot be readily extracted, including detailed diagnostic information which is recorded in free text format as is information relating to the reasons given for specific hearing outcomes.

**Data analysis**

4.12 The data reported in the following sections have been provided by the MHTS in Hamilton. Details on the data checking procedures are provided in the Research Design and Methods section (see paragraphs 3.10 to 3.11). **All the data reported are for the time period October 2005 to December 2007**, unless otherwise stated.

4.13 All the tables and charts use data provided at the CRN level, unless the data are shown at the patient level, which are extracted with reference to the PIN. In the tables relating to applications, we have used the unique CRNs to represent the number of applications made. There are some differences in the bases used in the following tables and charts. For those relating to applications, we believe this is due to missing data on age, gender and local authority. These charts relate to 3561 applications. For tables and charts relating to hearings, the number of applications is 3389. The difference between the two figures for applications is an artefact of timing: all applications up to 31 December 2007 are included in data relating to application volumes but for data relating to hearings, only cases that have also had a hearing by 31 December 2007 will appear (see paragraph 3.10).

4.14 Hearings that had been scheduled before the end of December 2007 will appear in total hearings data, but if a subsequent hearing for that case occurred in 2008 this is excluded from the data. It should also be noted that the number of applications and the number of hearings reported will be greater than the actual numbers. This is because data on hearings will include all booked hearings and some of these will have either been rescheduled or cancelled if the application is withdrawn, before the hearing date. There will also be some double counting on tables and charts relating to applications as cases that have been opened in error are not currently being deleted from the system due to time constraints.

**CTO Applications**

4.15 The data show that over 3500 CTO applications were received between October 2005 and December 2007. There have been variations over time in the number of applications submitted and between-month fluctuations but no obvious seasonal trends were discernable.

4.16 Since October 2005 the number of applications per month has stabilised and in 2007, compared to 2006, there was less variation month on month with the highest fluctuation in 2006 being 43, whereas by 2007 this had reduced to 24.
Figure 4.1 CTO Applications by Month (including moving average trendline)

4.17 The number of applications submitted varied greatly across the country with, not surprisingly, the largest number of applications submitted from the largest local authorities. Glasgow City submitted 17% of all applications compared with 12% from Edinburgh City, 9% from Fife and 5% from Highland and Aberdeen City.
4.18 Expressed as a rate per 100,000 population, Glasgow City not only dealt with the largest number of applications, but also had the highest rate of applications per head of population. Other local authorities that have high application rates by population were Dundee City, Edinburgh City, Aberdeen City, Perth & Kinross and Fife. Although Highland Council dealt with the fifth highest volume of applications in Scotland, it only had the ninth highest rate of applications per population.
Figure 4.3 Application Rates per 100,000 Population

Notes to table
Base: 3494 cases. 67 cases with missing local authority data excluded. Total cases = 3561.

4.19 CTO applications by gender were split fairly evenly - 48% for females and 52% for males. Over half (59%) of CTO applications were submitted for people aged between 16 and 50.

Table 4.1 Age of CTO Subjects

<table>
<thead>
<tr>
<th>Age</th>
<th>% of CTO applications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 16</td>
<td>1</td>
</tr>
<tr>
<td>16-35</td>
<td>29</td>
</tr>
<tr>
<td>36-50</td>
<td>30</td>
</tr>
<tr>
<td>51-65</td>
<td>18</td>
</tr>
<tr>
<td>Over 65</td>
<td>23</td>
</tr>
<tr>
<td>Base</td>
<td>3549</td>
</tr>
</tbody>
</table>

Notes to table
Base: 3549 cases. Assumes missing data for age in 12 cases. Total cases = 3561. % sum to more than 100% due to rounding.

4.20 A higher percentage of CTO applications were submitted by Highland Council for people aged over 65 (24%), compared to Edinburgh City and Glasgow City Councils. In comparison, Glasgow City submitted the highest percentage of applications for people aged under the age of 35 years (32%).

22
Table 4.2  Age of CTO Applicants by local authority Case Study Areas

<table>
<thead>
<tr>
<th></th>
<th>Edinburgh City</th>
<th>Glasgow City</th>
<th>Highland</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>35 and under</td>
<td>29</td>
<td>32</td>
<td>27</td>
</tr>
<tr>
<td>36 – 50</td>
<td>34</td>
<td>34</td>
<td>32</td>
</tr>
<tr>
<td>51 – 65</td>
<td>19</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>65+</td>
<td>17</td>
<td>18</td>
<td>24</td>
</tr>
<tr>
<td>Bases</td>
<td>413</td>
<td>579</td>
<td>177</td>
</tr>
</tbody>
</table>

Notes to table
Extracted from table with all 32 local authorities containing a total of 3389 cases.

4.21 Since October 2005, most people who have been the subject of an application have only had one application submitted to the MHTS. However, out of a total of 3206 individuals who have been the subject of a CTO application, approximately 10% (320/3206), have been the subject of two, three or four CTO applications.

Table 4.3  CTO Applications per Patient

<table>
<thead>
<tr>
<th>Number of applications</th>
<th>% of applications</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>90</td>
</tr>
<tr>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Base</td>
<td>3206</td>
</tr>
</tbody>
</table>

Notes to table
Base of 3206 individuals, using Patient Identification Number. Totals to 3554 cases, assumes missing data on 7 applications. Total cases = 3561. Percentages less than 1% are not shown.

CTO Application Timescales

4.22 For nearly two-thirds of CTO applications, the time between the MHTS inputting the application form and the date of the first hearing was six - ten days. For only 11% of cases, the hearing date was set for five days or less after the receipt of the application.
Table 4.4  Days from Application Received to 1st Hearing

<table>
<thead>
<tr>
<th>Number of days from App to 1st Hearing</th>
<th>% of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5</td>
<td>11</td>
</tr>
<tr>
<td>6-10</td>
<td>63</td>
</tr>
<tr>
<td>11-15</td>
<td>19</td>
</tr>
<tr>
<td>16-20</td>
<td>4</td>
</tr>
<tr>
<td>21-25</td>
<td>2</td>
</tr>
<tr>
<td>26-30</td>
<td>1</td>
</tr>
<tr>
<td>31 +</td>
<td>1</td>
</tr>
<tr>
<td><strong>Base</strong></td>
<td>3332</td>
</tr>
</tbody>
</table>

Notes to table
Missing data for 57 cases. Base is 3389 cases.
Figures add up to more than 100% due to rounding.

4.23 We had intended to report on data relating to the timescales of CTO applications for those on short-term detention orders, but have concerns about the validity of these data and they are not, therefore, included.

**Hearing Venues and Attendees**

4.24 We received data for a total of 85 venues that have, or had, been used (some are no longer in use) to hold Tribunal hearings for CTO applications since October 2005.

4.25 Sixteen of the top twenty most used venues were hospitals, probably reflecting the number of CTOs applied for those currently in hospital, often subject to a short-term detention order, rather than people living in the community. Community venues were, however, also used for in-patients where an alternative venue was not available at short notice. Thirty-three of the eighty-five venues have held 10 hearings or fewer between October 2005 and December 2007. The 20 venues that have been used most frequently appear in Table 4.5 below.
Table 4.5  Hearings Venues

<table>
<thead>
<tr>
<th>Venue</th>
<th>Location</th>
<th>Hospital or Community Venue</th>
<th>% of hearings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Edinburgh Hospital</td>
<td>Edinburgh</td>
<td>Hospital</td>
<td>13</td>
</tr>
<tr>
<td>Parkhead Hospital</td>
<td>Glasgow</td>
<td>Hospital</td>
<td>9</td>
</tr>
<tr>
<td>Royal Cornhill Hospital</td>
<td>Aberdeen</td>
<td>Hospital</td>
<td>8</td>
</tr>
<tr>
<td>Leverndale Hospital</td>
<td>Glasgow</td>
<td>Hospital</td>
<td>8</td>
</tr>
<tr>
<td>Argyle House</td>
<td>Edinburgh</td>
<td>Community</td>
<td>5</td>
</tr>
<tr>
<td>McKinnon House, Stobhill</td>
<td>Glasgow</td>
<td>Hospital</td>
<td>5</td>
</tr>
<tr>
<td>Elizabeth House</td>
<td>Kirkcaldy</td>
<td>Community</td>
<td>5</td>
</tr>
<tr>
<td>Larch House</td>
<td>Inverness</td>
<td>Community</td>
<td>5</td>
</tr>
<tr>
<td>Gartnavel Royal Hospital</td>
<td>Glasgow</td>
<td>Hospital</td>
<td>5</td>
</tr>
<tr>
<td>Careview Centre</td>
<td>Dundee</td>
<td>Hospital</td>
<td>5</td>
</tr>
<tr>
<td>Ailsa Hospital</td>
<td>Ayr</td>
<td>Hospital</td>
<td>4</td>
</tr>
<tr>
<td>Lynebank Hospital</td>
<td>Dunfermline</td>
<td>Hospital</td>
<td>4</td>
</tr>
<tr>
<td>Murray Royal Hospital</td>
<td>Perth</td>
<td>Hospital</td>
<td>4</td>
</tr>
<tr>
<td>Crichton Royal Hospital</td>
<td>Dumfries</td>
<td>Hospital</td>
<td>4</td>
</tr>
<tr>
<td>Falkirk &amp; District Royal Infirmary</td>
<td>Falkirk</td>
<td>Hospital</td>
<td>3</td>
</tr>
<tr>
<td>St Johns Hospital</td>
<td>Livingston</td>
<td>Hospital</td>
<td>3</td>
</tr>
<tr>
<td>Hairmyres Hospital</td>
<td>East Kilbride</td>
<td>Hospital</td>
<td>3</td>
</tr>
<tr>
<td>Blythswood House</td>
<td>Renfrew</td>
<td>Community</td>
<td>3</td>
</tr>
<tr>
<td>Stratheden Hospital</td>
<td>Cupar, Fife</td>
<td>Hospital</td>
<td>3</td>
</tr>
<tr>
<td>Ravenscraig Hospital</td>
<td>Greenock</td>
<td>Hospital</td>
<td>2</td>
</tr>
</tbody>
</table>

Notes to table
Percentages are based on top 20 venues. Base is 4254 hearings.
Includes booked hearings that may have subsequently been rescheduled or cancelled.

4.26 The data on the number of attendees at each hearing has only recently been systematically recorded (October 2007) and therefore all percentages, in Table 4.6 below, are based on a total of 552 hearings. The data shown assume that only one of any type of attendee went to a particular hearing.

4.27 Almost all hearings (98%) were attended by an RMO and 94% were attended by an MHO. Patients were present at nearly 60% of hearings and a third of patients had an appointed legal representative who attended the hearing. There was a Named Person present at 53% of the hearings, but it is not possible to say whether these were accompanying a patient attending the hearing or were attending in the patient’s absence.

4.28 It is not possible to report on the number of hearings attended by independent advocacy workers as they are not recorded as a separate category on the form which captures this information. They will therefore appear under the category of ‘Other Person With Interest’.
Table 4.6  Hearing Attendees by Type

<table>
<thead>
<tr>
<th>Count of Attendees by type (552 Hearings)</th>
<th>Number of attendees</th>
<th>% of hearings attended by type</th>
</tr>
</thead>
<tbody>
<tr>
<td>RMO or Approved Medical Practitioner</td>
<td>542</td>
<td>98</td>
</tr>
<tr>
<td>MHO</td>
<td>519</td>
<td>94</td>
</tr>
<tr>
<td>Patient</td>
<td>328</td>
<td>59</td>
</tr>
<tr>
<td>Named Person</td>
<td>291</td>
<td>53</td>
</tr>
<tr>
<td>Patient Legal Representative</td>
<td>184</td>
<td>33</td>
</tr>
<tr>
<td>Nurse in Charge</td>
<td>82</td>
<td>15</td>
</tr>
<tr>
<td>CPN</td>
<td>68</td>
<td>12</td>
</tr>
<tr>
<td>Curator Ad Litem</td>
<td>48</td>
<td>9</td>
</tr>
<tr>
<td>Primary Carer</td>
<td>45</td>
<td>8</td>
</tr>
<tr>
<td>Local Authority legal representative</td>
<td>29</td>
<td>5</td>
</tr>
<tr>
<td>Person of Skill</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>Named Person legal representative</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Curator Legal Representative</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Guardian</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Welfare Attorney</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>GP</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Medical Records</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Interpreter</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Mental Welfare Commission</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Other Person With Interest</td>
<td>655</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Total Number Of Attendees</strong></td>
<td><strong>2911</strong></td>
<td></td>
</tr>
</tbody>
</table>

Notes to tables
75 observers have attended these hearings.
More than one person of each type may have attended each hearing so % are indicative only.

CTO Hearings and Outcomes

4.29  The total number of hearings that have taken place for Compulsory Treatment Order applications between October 2005 and December 2007 was 5704 (see Table 4.7).

4.30  The data suggest that there were no major differences between local authorities in the number of hearings that took place per case (see Figure 4.2) with the largest local authority areas in relation to population size also convening the largest number of hearings. Glasgow City held 19% of all Tribunal hearings in Scotland, followed by Edinburgh City 13%, Fife 9%, and Highland Council 5%. These figures are very similar to the percentages of applications submitted by these local authorities.
### Table 4.7  Hearings by local authority

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>% of hearings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aberdeen City</td>
<td>5</td>
</tr>
<tr>
<td>Aberdeenshire</td>
<td>2</td>
</tr>
<tr>
<td>Angus</td>
<td>1</td>
</tr>
<tr>
<td>Argyll and Bute</td>
<td>2</td>
</tr>
<tr>
<td>Clackmannanshire</td>
<td>1</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>3</td>
</tr>
<tr>
<td>Dundee City</td>
<td>3</td>
</tr>
<tr>
<td>East Ayshire</td>
<td>1</td>
</tr>
<tr>
<td>East Dunbartonshire</td>
<td>1</td>
</tr>
<tr>
<td>East Lothian</td>
<td>2</td>
</tr>
<tr>
<td>East Renfrewshire</td>
<td>1</td>
</tr>
<tr>
<td>Edinburgh City</td>
<td>13</td>
</tr>
<tr>
<td>Eilean Siar (Western Isles)</td>
<td>0</td>
</tr>
<tr>
<td>Falkirk</td>
<td>3</td>
</tr>
<tr>
<td>Fife</td>
<td>9</td>
</tr>
<tr>
<td>Glasgow City</td>
<td>19</td>
</tr>
<tr>
<td>Highland</td>
<td>5</td>
</tr>
<tr>
<td>Inverclyde</td>
<td>2</td>
</tr>
<tr>
<td>Midlothian</td>
<td>1</td>
</tr>
<tr>
<td>Moray</td>
<td>1</td>
</tr>
<tr>
<td>North Ayrshire</td>
<td>3</td>
</tr>
<tr>
<td>North Lanarkshire</td>
<td>3</td>
</tr>
<tr>
<td>Perth &amp; Kinross</td>
<td>3</td>
</tr>
<tr>
<td>Renfrewshire</td>
<td>2</td>
</tr>
<tr>
<td>Scottish Borders</td>
<td>0</td>
</tr>
<tr>
<td>Shetland Islands</td>
<td>2</td>
</tr>
<tr>
<td>South Ayrshire</td>
<td>2</td>
</tr>
<tr>
<td>South Lanarkshire</td>
<td>4</td>
</tr>
<tr>
<td>Stirling</td>
<td>1</td>
</tr>
<tr>
<td>West Dunbartonshire</td>
<td>2</td>
</tr>
<tr>
<td>West Lothian</td>
<td>3</td>
</tr>
<tr>
<td><strong>Base</strong></td>
<td><strong>5704</strong></td>
</tr>
</tbody>
</table>

4.31 In relation to local authorities, there was some difference in the gender of patients from different authorities who attended hearings. Stirling, Aberdeenshire, Aberdeen and West Lothian had the highest proportion of male patients attending hearings in Scotland (66%, 62%, 61% and 60% respectively). The highest proportion of female patients who attended hearings in Scotland was found in East Renfrewshire (58%), North Ayrshire (57%), East Lothian (56%) and Renfrewshire (56%).

4.32 The majority of patients who were subject to a CTO application had attended more than one hearing, 55%. Over a third, 37%, attended two hearings and a further 14% had attended three hearings.
Table 4.8  Number of Hearings per patient

<table>
<thead>
<tr>
<th>No of hearings</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1420</td>
<td>45</td>
</tr>
<tr>
<td>2</td>
<td>1168</td>
<td>37</td>
</tr>
<tr>
<td>3</td>
<td>458</td>
<td>14</td>
</tr>
<tr>
<td>4</td>
<td>91</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>31</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>7+</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>3177</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note to table
Base: 5700 hearings - missing data for 4 hearings.

4.33  A specific objective of the research was to look at the outcomes of the hearings and the number of interim orders granted which would lead to at least one subsequent hearing. The number of interim orders granted has changed over time from October 2005 to December 2007, ranging from a low of 50 in December 2005 (ignoring October 2005, the first month of operation) to a high of 108 in June 2007. There were monthly fluctuations, but examination of quarterly trends showed a steady rise to Quarter 2 2007 followed by a slight reduction. Analysis of data for 2008 will show whether this downward trend has continued or whether the level of iCTOs granted has stabilised.

Table 4.9  CTOs and Interim CTOs Granted by Quarter

<table>
<thead>
<tr>
<th></th>
<th>CTO Granted</th>
<th>Interim Order Granted</th>
<th>Other*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>2005 Quarter 4</td>
<td>215</td>
<td>55</td>
<td>116</td>
</tr>
<tr>
<td>2006 Quarter 1</td>
<td>257</td>
<td>46</td>
<td>218</td>
</tr>
<tr>
<td>2006 Quarter 2</td>
<td>308</td>
<td>45</td>
<td>257</td>
</tr>
<tr>
<td>2006 Quarter 3</td>
<td>349</td>
<td>50</td>
<td>248</td>
</tr>
<tr>
<td>2006 Quarter 4</td>
<td>254</td>
<td>41</td>
<td>263</td>
</tr>
<tr>
<td>2007 Quarter 1</td>
<td>308</td>
<td>44</td>
<td>293</td>
</tr>
<tr>
<td>2007 Quarter 2</td>
<td>294</td>
<td>41</td>
<td>304</td>
</tr>
<tr>
<td>2007 Quarter 3</td>
<td>285</td>
<td>43</td>
<td>274</td>
</tr>
<tr>
<td>2007 Quarter 4</td>
<td>278</td>
<td>42</td>
<td>274</td>
</tr>
</tbody>
</table>

Notes to table
Base: 5693 hearings. Assumes missing data of 11. Total hearings = 5704. Percentages are in rows.
* Case withdrawn, CTO refused, hearing adjourned, hearing cancelled, patient deceased, revoked.

4.34  There has been a change over time in the proportions of hearings that result in a CTO or an interim CTO. The percentage of hearings ending in a CTO has reduced from a high of 55% in Quarter 4 2005 to 42% in Quarter 4 2007. At the same time the percentage of hearings resulting in an interim CTO has increased from 30% in Quarter 4 2005 to 41% in Quarter 4 2007. The following graph shows that, since the last quarter of 2006, the number of CTOs and iCTOs that have been granted has been very similar.
4.35 The number of interim CTOs granted varied according to the local authority area. West Dunbartonshire and East Renfrewshire had the highest levels of interim CTOs (51% and 49% respectively). Glasgow City Council had a similarly high level at 46% compared to Edinburgh and Highland Councils that had rates closer to the average of 39% (40% and 37% respectively). North Ayrshire and Dundee City Council saw the lowest proportion of interim CTOs at 25% and 28%.
Figure 4.5  Hearing Outcomes by Local Authority

![Figure 4.5 Hearing Outcomes by Local Authority](image)

**Notes to table**
Base: 5693 hearings. Assumes missing data of 11. Total hearings = 5704

4.36 The level of interim orders granted has meant that over half of all cases (52%) had more than one hearing, 38% had two hearings and 14% had three or more hearings.

**Table 4.10 Number of Hearings per Case**

<table>
<thead>
<tr>
<th>No. of Hearings</th>
<th>% of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>48</td>
</tr>
<tr>
<td>2</td>
<td>38</td>
</tr>
<tr>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>4+</td>
<td>1</td>
</tr>
</tbody>
</table>

*Base: 3389 cases linked to 5704 hearings.

4.37 Before the MHSA (2003), all patients receiving compulsory treatment did so in hospital. The 2003 Act allows for both hospital and community-based compulsory treatment orders to be granted. Only one in eight CTOs granted (13%) between October 2005 and December 2007 were community-based orders. There was some variation depending on local authority, with the highest level of community-based orders granted in Stirling Council (27%) and the lowest level in Dumfries and Galloway (3%). Edinburgh and Glasgow Councils saw just over the average rate of community orders at 15% and Highland Council saw the average, 13%.
Table 4.11  Community and Hospital CTOs by Local Authority

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Community Orders Granted (%)</th>
<th>Hospital Orders Granted (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aberdeen City</td>
<td>13</td>
<td>87</td>
</tr>
<tr>
<td>Aberdeenshire</td>
<td>11</td>
<td>89</td>
</tr>
<tr>
<td>Angus</td>
<td>8</td>
<td>92</td>
</tr>
<tr>
<td>Argyll and Bute</td>
<td>10</td>
<td>90</td>
</tr>
<tr>
<td>Clackmannanshire</td>
<td>21</td>
<td>79</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>3</td>
<td>97</td>
</tr>
<tr>
<td>Dundee City</td>
<td>5</td>
<td>95</td>
</tr>
<tr>
<td>East Ayrshire</td>
<td>22</td>
<td>78</td>
</tr>
<tr>
<td>East Dunbartonshire</td>
<td>18</td>
<td>82</td>
</tr>
<tr>
<td>East Lothian</td>
<td>9</td>
<td>91</td>
</tr>
<tr>
<td>East Renfrewshire</td>
<td>11</td>
<td>89</td>
</tr>
<tr>
<td>Edinburgh City</td>
<td>15</td>
<td>85</td>
</tr>
<tr>
<td>Eilean Siar (Western Isles)</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Falkirk</td>
<td>14</td>
<td>86</td>
</tr>
<tr>
<td>Fife</td>
<td>16</td>
<td>84</td>
</tr>
<tr>
<td>Glasgow City</td>
<td>15</td>
<td>85</td>
</tr>
<tr>
<td>Highland</td>
<td>13</td>
<td>87</td>
</tr>
<tr>
<td>Inverclyde</td>
<td>18</td>
<td>82</td>
</tr>
<tr>
<td>Midlothian</td>
<td>24</td>
<td>76</td>
</tr>
<tr>
<td>Moray</td>
<td>14</td>
<td>86</td>
</tr>
<tr>
<td>North Ayrshire</td>
<td>9</td>
<td>91</td>
</tr>
<tr>
<td>North Lanarkshire</td>
<td>8</td>
<td>92</td>
</tr>
<tr>
<td>Perth &amp; Kinross</td>
<td>8</td>
<td>92</td>
</tr>
<tr>
<td>Renfrewshire</td>
<td>17</td>
<td>83</td>
</tr>
<tr>
<td>Scottish Borders</td>
<td>21</td>
<td>79</td>
</tr>
<tr>
<td>Shetland Islands</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>South Ayrshire</td>
<td>22</td>
<td>78</td>
</tr>
<tr>
<td>South Lanarkshire</td>
<td>8</td>
<td>92</td>
</tr>
<tr>
<td>Stirling</td>
<td>27</td>
<td>73</td>
</tr>
<tr>
<td>West Dunbartonshire</td>
<td>11</td>
<td>89</td>
</tr>
<tr>
<td>West Lothian</td>
<td>3</td>
<td>97</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
<td><strong>87</strong></td>
</tr>
<tr>
<td><strong>Bases</strong></td>
<td><strong>337</strong></td>
<td><strong>2,195</strong></td>
</tr>
</tbody>
</table>

**Key findings**

- The data management systems used at MHTS were developed to store information to process CTO applications and enable them to set up hearings at short notice. They were not designed as a monitoring tool to provide accurate and easy to access statistical data.
- Data are also not always recorded on the Case Management System in a way that allows it to be used to produce statistics.
- The number of CTO applications received between October 2005 and December 2007 was over 3,500 which resulted in approximately 5,700 hearings being held. There were no major differences in the gender or age of those who were subject to a CTO application, however there were some regional variations.
• The venues that were used the most tended to be hospital, rather than community based, 16 out of the top 20 most used venues.
• Sixty per cent of hearings were attended by patients and at a third of hearings patients have a legal representative.
• In over 50% of cases more than one hearing was required to make a full decision on each application.
• Although the total number of hearings has fluctuated and changed over time, the balance between the proportion of CTOs and iCTOs being granted has been stable since October 2006.
• Most of the CTOs granted were for hospital-based treatment (87%) rather than for treatment in the community (13%), although there was regional variation.
CHAPTER FIVE   THE EARLY OPERATION OF THE MHTS

5.1 This chapter presents the views, experiences and perceptions of a range of informants who have, in different ways, had a role in the development and early operation of MHTS. The chapter draws on the key informant interviews, the mini group discussions with tribunal panel members, notes taken throughout the system mapping event, and where relevant - comments received as part of the cost gathering exercise. Verbatim quotes are used to illustrate key points.7

5.2 While certain roles and the respective responsibilities of different players might appear to be based on shared understandings, it is not unusual – especially in the early days of a new service or initiative – for there to be a blurring of roles or a lack of shared clarity. We therefore begin by discussing informants’ perceptions of their different roles within the MHTS. We then explore perceptions and experiences of the key processes at the heart of the Tribunal system - Compulsory Treatment Order (CTO) applications and the hearings themselves, as well as perceptions of factors underlying the possibly higher than expected use of Interim CTOs (iCTO). Finally, informants’ views of the efficiency and efficacy of the MHTS are considered.

Roles within MHTS

5.3 The range of people interviewed is outlined in Table 3.1. Our purpose here is to describe how respondents perceived these roles and the responsibilities they entail.

Mental Health Officers

5.4 The main role of the Mental Health Officer (MHO) in relation to CTOs, as described by respondents, is to create CTO applications and to demonstrate why a CTO is required. Decisions to submit a CTO application are usually made around the second week of a short term detention order: the main reason for this is to give the patient enough time to respond to any treatment or to recover - and to give the MHO enough time to prepare the CTO application. This has important consequences for the planning and preparation of hearings, which are discussed in paragraphs 5.21-5.30. MHOs also have a responsibility to inform the patient of their legal right to a solicitor and to contact advocacy services on the patient’s behalf. The role of an MHO in the hearing can vary depending on the convenor: sometimes they may be asked to present their case, while at other times, they may say very little in the course of a hearing.

“Some conveners sort of chair things in a very sort of set pattern and you get to know that and you know some of them nearly take over completely and others very much look towards MHOs to say you know you start off this process you present your case you make an argument kind of thing so it varies a lot.” (MHO)

7 Verbatim quotes are referenced by informant category (e.g. MHO), unless this would identify the actual informant.
**Advocacy Workers**

5.5 The role of advocacy workers was described as ‘providing support’ and ‘to put the patient’s views across’ during a hearing. Advocacy workers said that they liked to get involved before the hearing to make sure the patient understands what the tribunal means, how it operates and explain the criteria that have to be met before the CTO can be granted. The level of support an advocate gives depends on the needs and wishes of the patient. At times it may be a purely supporting role – where they are asked to attend the hearing but say nothing, while at other times it may be a more direct role where the patient will ask their advocate to speak on their behalf or read out a statement which they have prepared in advance. Advocates may also play a central role in making sure that the language used in the hearing is understood by the patient – for example, asking for descriptions in lay terms, and challenging evidence given at the hearing. One advocate recalled a hearing where the MHO had given factually inaccurate details:

“At the hearing, the MHO sort of said that the neighbours are concerned about her. She was causing problems with the neighbours. She was in arrears. She had nothing in the flat whatsoever. Just basically talking on hearsay. And I said, 'Well no. That's not the case. Look.', you know?” (Advocacy worker)

5.6 Patients may be referred to advocacy support services by MHOs, psychiatrists, care and support agencies, or relatives. In some cases, they may self-refer, often having found out about the service through word of mouth.

**Solicitors**

5.7 A solicitor’s role is to represent patients’ legal rights. If they feel that there is insufficient evidence or if the patient is opposed to the order they may try to prevent a detention order. They may be present at a hearing simply at a patient’s request, not to prevent a CTO, but to act as an advisor. If a patient does want to oppose an order, the solicitor will go through the application to ensure that it is a fair assessment of the patient’s status. An Independent Medical Report may be requested.

“If the patient turned round to me and said, 'I don’t want to oppose the application', then really my role then becomes an advisory or a role just to kind of assist them through the hearing itself, with the minimum of disruption and upset for them. If the patient says to me, 'I don’t want the order granted' or 'I don’t want to be in hospital. I want to be back at home', then what I have to do is go through with them the case – which is basically the MHO and RMO report. I go through the case with them and say to them 'Well, you know, when this bit .. Is there anything we could say that might say that that’s wrong?' or 'Is there anybody who could speak up on your behalf who might be able to contradict that?', and try at that stage and see what evidence is available –if any – to balance against the evidence in the report.” (Solicitor)
**Responsible Medical Officers**

5.8 Like MHOs, RMOs also have to prepare paperwork for the CTO application and attend the hearing to give evidence, explain why the CTO is required and answer any questions put to them by the panel. Preparing paperwork requires the RMO to visit the patient and speak to relevant parties (e.g. Named Person and the MHO).

**National bodies**

5.9 The Mental Welfare Commission (MWC) has a broad remit to monitor the operation of the Mental Health Act (MHSA), with a focus on the patient. This includes ensuring that no-one is detained unlawfully under the Act and monitoring the care and treatment people are given. They can also be copied into letters from Advocacy workers to the Tribunal and receive feedback from service users. They will follow-up ‘rights-based issues’ such as people not feeling listened to, but matters of judicial concerns are not dealt with by the MWC and they have no power to overrule a decision by a tribunal.

**Frequency of hearings**

5.10 Many of the panel members and our key informant respondents had been involved with the MHTS since its inception in October 2005, and attend approximately three or four hearings per month. There were, however, some medical panel members – mostly retired practitioners - who attended several hearings a month. The sporadic nature of hearings was also noted. Some respondents commented that they may have to attend several hearings within a short period of time and then have months when they attend none.

\[\text{“It tends to be little sort of runs, and then not for a long time.” (RMO)}\]

5.11 Most panel members have other jobs outside the MHTS – for example, convenors working in private law practice and general members working as social workers, while some also sat on other tribunals, such as Shrieval and Immigration Tribunals.

**Level of pay and conditions**

5.12 While the pay and conditions for panel members were not explicitly addressed within the interviews and groups, the topic was raised by some respondents:

- Full fees are paid to panel members if the hearing is cancelled within two days, although there was some confusion as to whether this was changing or not\(^8\).
- Level of pay for panel members was perceived as being generous. However, convenors are paid an extra £50 for writing up the determination and this was criticised as being too little for the responsibility this entails.
- Panel members in the central belt have been paid mileage to attend hearings in Highland, but Highland panel members living in Inverness do not get paid to attend hearings outside of Inverness, which was felt unfair.

\(^8\) This was changed on 1\(^{st}\) June 2008 to 50% if the hearing was cancelled within 72 hours.
5.13 Discussion from the system mapping event, along with emails from participants contacted to explore MHTS costs also indicated resource issues which adversely affected the management of CTO applications – for example, difficulty arranging out-of-hours cover and having enough MHOs to cope with the number of CTO applications. While this was apparent for all three case study areas, it appeared especially problematic for Highland, with one MHO noting that a typical working day can be around 10½ hours. A large proportion of this time can be spent travelling to see clients and attend a hearing, and it was apparently not unusual for MHOs to have to travel 200 miles in one day. There were also problems associated with a lack of administrative and other resources. It was commented that without administrative support and a laptop computer, CTO applications and associated paperwork could only be completed within the office. It was felt that the pressure placed on MHOs was unsustainable and it was suggested that ‘people have already voted with their feet.’

“There appears to be a total absence of understanding of wear and tear upon MHO’s. We are in a position of being the ones with most responsibility under the Act to be ‘moral brokers’ to the system. We are the least well paid and appreciated.”

CTO applications

5.14 Before a decision is made to submit a CTO application, discussion will take place with the MHO and usually the patient’s psychiatrist and/or their GP to assess whether criteria for a CTO are met. In Highland, this takes the form of a case conference. Discussions from the system mapping event suggest that the decision making process to apply for a CTO varied across local authorities, and no standard approach is used - highlighting the complexity of the MHTS. As summarised by one system mapping participant’s evaluation form.

“To see the system mapped out as it was made me realise how complex the system is and how many individuals are involved.”

Writing the application

5.15 The amount of time taken to complete and submit a CTO application can vary depending on the case, but the consensus was that it generally took two to three days in total. Putting together an application was regarded as particularly problematic in Highland because it can be more difficult to get hold of people, and also to decide whether to apply for a community or hospital order as services vary greatly in different areas. It can also be difficult to obtain a medical report from Highland GPs, especially if the patient is in hospital already. With the only hospital in Inverness, GPs may not be willing or able to travel to see the patient and write the report. Consequently, it is common for medical reports to be written by two hospital consultants – not an ideal situation as it is highly likely that they will both work in the same hospital, and may compromise the autonomy of the second report.

“...it can be tricky with GP’s coming to see people because everybody’s in hospital in Inverness. Ideally I think you would, I’m much happier if you can have the, the consultant and the GP putting in medical reports rather than 2 hospital consultants. But that is quite common here [Highland] because a GP will refuse to come let’s say
from Skye to Inverness to see a patient... and even GP’s close by in Inverness or Nairn sometimes say no I don’t have the time to do that I’m not prepared to do that.”

Submission of CTO application

5.16 A practical problem the MHTS faces is how CTO applications are sent to the administration office in Hamilton. A variety of methods were used and include posting by recorded delivery, delivery by hand or by courier. While it was acknowledged that applications should be sent to the administration by email, there were a number of reasons why this was not happening, including concerns about data security issues, lack of IT equipment such as scanners, or simply a general reluctance to use email. MHOs were generally not email-resistant, and some expressed frustration with the current methods because of the time it can take to organise posting the forms or delivering them by hand.

“We physically take the papers up to the XXXX Hospital from the office we are at and I am not based there, most MHOs aren’t based there, we have to bring them up there and they are then couriered down to Hamilton to the tribunal centre. I know that there has been experiments up and down the country of being able to email applications on secure lines down to Hamilton, but XXXX hasn’t got a sufficiently secure emailing system yet that would allow that to happen. But I believe it may be available at some point in the future.”

Interviewer: “and what do you feel about that whole process of getting the application?”

“Well it’s a pain, you have to phone up to make sure that there is a courier there, a courier booked for that day, and that can be quite frustrating because there isn’t always one.” (MHO)

5.17 The MHTS administration office in Hamilton shares the MHOs’ frustration with the current situation. The research highlighted a general confusion as to why emailing CTO applications was not happening, and a lack of clarity about whose responsibility it was to resolve the difficulties or when this might happen. At the time of the research, a pilot for electronic submission was operating, with some local authorities. The results of this should facilitate roll-out of electronic implementation to all areas.
Problems with the CTO application form

5.18 Despite previous revisions to the CTO application, there continue to be difficulties. These focus, in particular, on the amount of information required and concerns that an MHO may have to repeat the same information in different parts of the form. Writing the care plan was perceived as frustrating for some because of layout problems. In addition, there was irritation about the PDF format of the forms which limited the number of characters that can be used in some boxes, and created difficulties editing entries.

“The care plan section of the application I find really very annoying because of the way it’s broken down. You sometimes you sort of have to look at it and say what this is supposed to mean. I mean I, I do them a lot, I do these forms a lot because I don’t do anything else but I think people who don’t fill in these forms very often will look at them and think what is this bit supposed to mean you know and you’ve already told them somewhere else so you then basically have to repeat this in some slightly different worded you know format. ...In my view the care plan section is the most cumbersome and sort of stupid looking form you know you could summarise and you’d make it much easier than it is at the moment.” (MHO)

“The only problem I suppose with the new form – again, it’s another daft wee practical thing – is that when you’re doing the boxes, filling in .. if you’re typing them in, you suddenly get cut off half way down the box. It doesn’t take any more script, you know? You’ve then got to go on to the extension sheets, which is a bit daft. They should have expandable boxes.” (MHO)

Hearings

Named persons

5.19 Although, named persons were not the focus of this research (a separate study focusing specifically on named persons has been commissioned), it is worth noting that the system mapping event and mini group discussion with panel members highlighted some concern over the appropriateness of named persons, who receive copies of all paperwork.

“I find it very difficult that there is this area in the act where you had a default named person where no investigations have been made as to whether this is a suitable person to be and especially in the very sensitive work that the Psychiatrists do, you are not aware whether a person who becomes a default named person might be an abuser or somebody that the patient has particular issues with and I think the fact that the paperwork goes to this person, I’m very ...that’s an area of grave concern.” (Panel member)
Short notice

5.20 If it is felt the patient would benefit from a longer period of compulsory treatment and care, a CTO application is usually the next step after a STDO. An STDO lasts for 28 days and once it expires, the MHSA allows five days in which a hearing must be convened and decision made on the appropriateness of the application or not. CTO applications tend to be submitted to the MHTS administration late in the STDO 28 day period. This can be for very good reasons as it may be in a patient’s best interest to assess whether care or treatment to that point has resulted in any improvement. However, this means there can be very little time to organise a hearing which, in turn, leads to the concerns, raised by several respondents including those who attended the system mapping event, about the short notice for hearings.

5.21 Applications to extend and vary an existing CTO or two year reviews tend to have longer notice periods as the paperwork is received in Hamilton earlier. CTO applications for people nearing the end of their SDTO take priority, which means applications sent to the office in good time may nevertheless have to wait.

5.22 There was a great deal of sympathy for the scheduling team at MHTS, as it was recognised that working within the five days time period set out in the Act was a difficult task.

“The tribunal, I think, has worked really hard, it’s an immensely difficult thing to do. Especially within the tight timescales that the Act imposes to be able to organise all of that and I have you know immense sympathy with them.”

5.23 Working within the five day notice period creates resource and planning issues for the administration in Hamilton: scheduling hearings at short notice means they have to have adequate staff to cope with busy periods, but they may also have quieter periods with fewer applications.

5.24 Short notice of hearings also creates problems for RMOs, solicitors and advocacy workers. It is not uncommon for an RMO to have to cancel previously arranged appointments with patients or clinics.

“It has a big impact because you have to miss ward rounds or cancel outpatients or I’m way behind on my paperwork.” (RMO)

5.25 Solicitors who are given short notice often do not have enough time to establish a ‘rapport’ with their client and may not have time to organise an Independent Medical Report which, in turn, can result in an interim order.

“The problems are where a short term detention certificate is granted, and then there has to be a hearing. You know, the application has to come in quite quickly, and a hearing fixed quite quickly thereafter. And those are the problem ones where you can be instructed the day, or two days, before the hearing. And obviously that is very difficult because, first and foremost, if it’s a client you’ve not met before then you’ve got to go through the whole process of establishing rapport with that client.” (Solicitor)
5.26 There is no requirement for the MHTS to notify advocacy workers of a hearing date, so they are usually told by the patient or the MHO. As a consequence there have been occasions where advocacy workers have been asked to attend on the day of the hearing itself. However, most have now taken a pro-active approach and will phone the Hamilton office to find out when the hearing is scheduled.

“What I’ve started doing, when I’m expecting one .. because I put in my diary when someone .. when their five days is up. So if someone say is due one this week, I’ll usually phone up on Monday and say, ‘Have you got a date for such and such?’”

(Advocacy worker)

5.27 Short notice of hearings may affect MHOs rather less than other people because, as they submitted the application, they can usually estimate when a hearing will take place. MHOs often attach a memo with the application to let Hamilton know dates they and the RMO cannot attend. The scheduling team will then try to accommodate them. However, sometimes it is not possible and another MHO or RMO will be required to attend in their place.

5.28 Opinions varied about ways to rectify the problem of late CTO applications and the subsequent short notice of the hearing date. Some respondents felt CTO applications should come in earlier - for example, by day 20 - to allow the administration office in Hamilton more time to process them and set up the hearing, while others felt this would be ‘ludicrous’ as it was not in the best interests of the patient because a decision would need to be taken early on in the 28 day detention, meaning there would be no time to see how a patient has responded to treatment.

5.29 Panel members were less likely to be affected by the short notice of hearings as their time is booked in advance. Thus, while they may receive the paperwork at short notice, they will already know what days they are working. However, some panel members felt that attending two hearings in one day can be difficult, especially if they need to travel some distance to get to a hearing, necessitating an early start and a late finish, but without additional remuneration as they are not paid beyond 5pm. Some suggested that it can also be stressful if the first hearing has run over and they do not have time to prepare for the second hearing. However, while most felt that two hearings in one day was a good idea if the hearings are short, there is no way of predicting how long a hearing might last and some said that they would refuse to do two hearings in one day for that reason.

“…if they phone you and ask you if you want to do a Tribunal, and you say 'No', there's nothing they can do to you. You're quite at liberty to say 'No', or 'Yea' or 'No'. So I mean I will say – and I, as I say, I'm quite happy to make that known – [that] if it's two Tribunals in Aberdeen, I will not go; because I know that, even if I go up the night before, I will not be home till 10 o'clock at night – and I'm not prepared to work a 13 hour day for the money that I'm paid. And it's as simple as that.”

(PANEL MEMBER)

9 It is should be noted that there is provision for panel members to claim additional payment if they work longer than 11 hours.
Hearing preparation

5.30 Unsurprisingly, preparation for a hearing depends on a person’s role in the hearing. Advocates and solicitors may spend a lot of time trying to establish a relationship with the patient to build up trust. The amount of time advocacy workers need to prepare can vary depending on the amount of support the patient requires and notice they have been given. Estimates ranged from a few hours to two or three days. Preparation for and attending a hearing takes priority over existing work, and like RMOs, advocacy workers felt this could be at the expense of other clients.

“One of the big things I’ve found is that, since the system came in, I’m dealing mostly with Tribunals, and sometimes I think that’s at the expense of the community.”
(Advocacy worker)

5.31 The focus of preparation for the MHO is completing and submitting the CTO application (discussed in paragraph 5.4) but they try to visit the patient and speak to the RMO before the hearing. If an Independent Medical Report is available, they will also read this before the hearing. These tasks can take up to one day.

5.32 Panel members need to download and print papers in advance of a hearing. This is usually done at home using their own PCs, and the papers are later given to the Hearing Clerk and shredded. There were some concerns about having confidential papers on family PCs, and some had requested the papers be posted to them instead. Panel members did not recall receiving any guidance on data protection. Generally, there were no problems accessing the papers, but some panel members have had occasions where they have gone into the system to view the papers only to find that they have been taken down before they have had a chance to see them and they found this both strange and inconvenient:

“….what I don’t understand is why papers can't remain up until the hearing day. I don’t understand why they have to kind of come up and then be taken off again.”
(Panel member)

5.33 It was common for panel members to read papers the day or night before the hearing, so it was fresh in their minds. The amount of time it takes to read the papers depends on the case and can range from 40 minutes to several hours, especially if they need to check something – such as medical members checking the medical reports or convenors referring to the Act. The panel will meet about one hour before the hearing to discuss points and areas requiring clarification. Some convenors spend time preparing the deliberation paperwork before the hearing – for example, putting in basic details and writing up the background – as this can save some time in the hearing.

5.34 Some panellists felt that the need for the convenor to write the determination on the day of the hearing caused unnecessary stress (for the convenor, especially if they are not the fastest typist) and delay for other panel members and hearing clerks. They would prefer to write the deliberation later on (like Shrieval tribunals) and liaise with panel members by telephone or email to check that the other panellists are happy with what has been written. It was also noted that there is no standard format for the preparation of the deliberation, with some convenors writing short deliberations and others writing ‘reams and reams’.

10 Papers are now left on the system until the day of the hearing.
Panel member 1: “It [typing the deliberation] has to be done on the day. You have
to sit there.”

Panel member 2: “And all the members have to wait. So if you’ve got somebody
plonking it out, as a convenor, you know? .. or if you have a very lengthy decision,
your two fellow members are sitting there with possibly limited input, because you
can’t type if somebody’s standing looking over you, you know?”

**Hearing duration**

5.35 In general, hearings are thought to last around half a day, but the duration varies and
depends on who is present, the convenor and the type of order sought. It is expected that
MHOs will attend and if they cannot (for example, they are on holiday), they will arrange for
a colleague to go in their place. RMOs are also expected to attend and if it is not possible for
them to attend in person, evidence can be taken by telephone or video conference. Not
surprisingly, these options are more common in Highland. Patients are encouraged to attend
hearings, but opinion was mixed as to whether it was common for them to attend a hearing on
not. In some cases, patients do attend but do not sit through the whole hearing because it can
be too stressful. If a patient does attend, the hearing can take longer because it is usual for
comfort breaks to be required. Other people who could be invited include family members
and CPNs and nurses. All can be asked to give evidence, which can make the process longer.
The tone and duration of a hearing are influenced by the convenor,

“Some are very focused, they're very clear, are 'efficient' I suppose is that word, and
some tend to get a bit bogged down and lost in the minutiae, which is perhaps more
time-consuming than it needs to be – and more often than not isn't helpful and doesn’t
really affect the outcome I don't think usually.”

**Perceptions of patients’ experiences**

5.36 In general, most respondents felt the new hearing system was fairer for patients than
the old Sheriff Court system. It was praised for being more, ‘patient focused’, open and
accountable, more friendly, and allowing patients to feel listened to (even if they do not agree
with the final decision) and have a voice.

“... I would say that it’s an improvement because the patient is sitting down with you
round a table. They're getting an opportunity to state their case. We can stop after
10 minutes if they're not feeling well. They can go to the toilet if they want. I mean
those are pretty minor examples, but everybody gets a chance to challenge, in a
pleasant way, the evidence.”

5.37 It was acknowledged that it can, however, be very upsetting for patients and
families to hear the evidence presented and have their mental ill health discussed in front of
strangers.
“Sometimes it may be [that] I'll go to a hearing with a person, and sometimes they can get quite upset about stuff which is being said, cause there's a lot of personal stuff said by a whole load of strangers.” (Advocacy worker)

5.38 Revisiting past details in their case history can also be very distressing for the patient. Some respondents questioned why evidence had to be read out in front of the panel (causing further distress for patient) when it was already written down. This sentiment was also expressed by system mapping participants, but it was acknowledged that sometimes when this happens it is often for good reason – for example, to clarify parts of the application.

“I do sometimes think that panels should pay more attention to what’s in the application. Often they ask to be told you know that, that the MHO or the RMO basically repeats what’s in the report already, and sometimes that can be upsetting to people, you know, to have all their symptoms recounted and may be nonsensical things repeated and worries or risk of being violent or something like that .. and I sometimes think panels should just take that as read and not ask for this all to be repeated.” (MHO)

5.39 Patients can get distressed when they struggle to articulate and ‘put their point across’, and families may also become upset if they do not understand mental illness and do not believe that their family member is unwell. Therefore, despite the new system trying to be fairer and more inclusive, it can still be an upsetting experience.

“...not everybody understands what mental health is about, and there are people who get very angry about it, family members, they think maybe services aren’t happening quick enough, or they don’t believe the person is unwell, or they don’t understand the risks that are involved by not treating somebody. ...if you are watching somebody articulate their views in a hearing in public, and they maybe doing a bad job of it, they maybe say things that embarrass them, they maybe...you know its just... If you are working with people that are unwell...you know somebody is unwell, and that person is desperately trying to get their point of view across and no matter how we try to accommodate that within the process, the tribunal is much more informal than the court but its still a formal process, with powers and the very fact that there are powers at stake is distressing for you know you as a practitioner even though you believe in what you are doing. The human element of somebody being stressed, angry, upset.” (MHO)

5.40 Delays in making a final decision about the appropriateness of the CTO were also perceived to have negative effects on the patient, especially if this results in an interim order. Some respondents argued that an iCTO is a ‘disservice’ as the patient could potentially be in hospital longer, whilst others felt an iCTO was an important ‘patient right’ and can be in the patient’s best interest. For example, an iCTO is often granted to obtain an Independent Medical Report which may challenge the medical reports and cast doubt over the need for a CTO.

5.41 It was also suggested that hearings can have a negative impact on the therapeutic relationship between a psychiatrist and patient, and between an MHO and patient, especially if the psychiatrist and/or MHO are giving evidence to endorse compulsory treatment which the patient does not want.
“So it is quite difficult because you obviously have to speak about them in front of them, if they are there in the hearing and say things that are quite at odds with the perception or belief. And also at the end of all that trying to maintain a working relationship, it is quite challenging.” (MHO)

Patients’ needs and venues

5.42 In general, patients’ needs (such as interpreters/translators, comfort breaks) are accommodated and everything is done to make the patient feel comfortable, with venues praised for being accessible for wheelchairs users. Because of the high number of asylum seekers, interpreters are more widely used in Glasgow than in Highland or Edinburgh.

5.43 When venues were mentioned, it was generally critical. Some venues were described as ‘wholly inadequate’, and some were criticised for having a lack of waiting rooms and/or rooms for patients to talk in private with their solicitor or advocacy worker. Hospital venues were criticised as being cramped or inappropriate.

“I've been to several venues, and there are always problems with finding somewhere private to go and speak to your client....So you've got the RMO, MHO, named person, escort nurses, family member – you know, everybody in the one room – and that can be tense if it's a difficult one....You know, sometimes there are no tea and coffee making facilities or whatever. You know, I mean there's just a general kind of difficulty sometimes with the facilities that are available.” (Solicitor)

5.44 Other venues were seen as being inappropriate for people to access by public transport and many respondents queried how the money to improve venues for hearings had been spent. (These comments refer to grants given to local authorities to improve mental health services in order to implement the Mental Health Scotland Act. See costs chapter for more detail).

“I think that Scottish Government allocated funds for venues. I'd like a summarised audit of where the money went because some venues are wholly inadequate. They're inadequate from access for the patient or the relatives.” (Panel member)

5.45 Opinions were divided regarding the use of community versus hospital venues for hearings. Some felt they should only be in hospital as it would be too disorientating for a hospital patient to travel outwith the hospital, while others felt community venues were better (regardless of whether the patient was in hospital or the community) because it reduced the stigma of mental ill health.

5.46 These sentiments were echoed by system mapping participants who felt some venues were better than others, and wondered whether a central venue in each region would be a better use of resources. This was dismissed by others as currently venues are arranged to accommodate the patient and that the closet venue for patients should be the preferred approach.
Recommendations for improvements to hearings

5.47 We asked the research informants to suggest ways in which they felt that the hearing process might be improved. It should be noted that the suggestions put forward reflect their perceptions and understandings of the process from their perspective. Indeed, some of the “recommendations” for change may already be in place, but the participants may have been unaware of changes. It may be that this, in turn, reflects a failure of communication rather than participants’ ignorance or misunderstanding.

5.48 Suggestions for improvement and change put forward by the research informants included:

- Email notification of paperwork rather than post to save time
- All people involved in the hearing should be called by the MHTS to notify them of the hearing dates rather than just the MHO and RMO
- Adjust the CTO application so it is easier to write more in boxes
- Enable MHOs to submit CTO applications on-line, via email
- Allow more time to prepare a hearing once a CTO application is submitted
- Make certain public holidays are non-tribunal working days to reduce costs and hearing ‘no-shows’
- Encourage hospital staff to explain the MHSA and tribunal process to patients
- Improve inappropriate venues
- Encourage patients to attend through a video link
- Ensure all hearing venues have a photocopier that can be used to copy paperwork received on the day of hearing, e.g. IMRs
- Consider allowing convenors to write determinations after the hearing rather than on the day.

Interim Compulsory Treatment Orders

5.49 This research was, in part, commissioned because of concerns about the number of iCTOs which it was felt were higher than originally anticipated when the MHTS was established in 2005. In general, respondents tended to concur with this view. However, opinions did vary: some thought the number had decreased since tribunals started, some felt the number had been too high since the very start, while others felt numbers were what they had expected. What is perhaps more interesting is that there were mixed views as to whether the number of iCTO was, in fact, problematic. Panel members pointed out what appears to be a contradiction between what the MHSA says and perceptions of the uses of an iCTO. The Act states an iCTO should always be considered before a CTO, yet panel members have been told iCTOs would be the exception and not the rule.

“When we did the original training, we were kind of told that there was this incredibly rare order you [laughter] would very occasionally have to use, called an 'interim'..'” (Panel member 1)

“So I mean from THAT perspective there were lots more [laughs]. It’s interesting to speculate how that opinion was formed.” (Panel member 1)
“Isn't there also something in the Act that if somebody's already been on a short term detention order, and you're looking at a first time CTO, that you have to consider an interim in the first instance?” (Panel member 2)

“That’s right. That’s right.” (Panel member 1)

“So it’s within the Act that you must initially consider an interim before going for a full order.” (Panel member 2)

Factors associated with perceived increased use of iCTOs

5.50 Despite the mixed views on the possibly problematic number of iCTOs or not, a number of suggestions were made to explain why the iCTOs are granted. The most common reasons cited were the need to appoint a Curator Ad Litem or to obtain an Independent Medical Report (IMR).

Convoluted Curator Ad Litem process

5.51 A Curator Ad Litem is appointed when a patient is deemed incapable of understanding the CTO process and making decisions themselves. The Curator’s role is to act in the patient’s best interest. In the early days of the new system, there appears to have been a rather convoluted process to appoint Curator Ad Litem. Before a Curator could be appointed, a “Man of Skill” had to ascertain whether a Curator was required or not. This all took time and it was not uncommon for the first hearing to go to an interim order because a curator had to be appointed and then, at the second hearing, the Curator would request an IMR. This could result in three hearings before the CTO was granted. Some respondents thought the process had been revised and that this had helped reduce the numbers of iCTOs. The system mapping event helped clarify that appointment of a Curator was being reviewed and in future, if required, should be appointed before the first hearing, something which several system mapping delegates did not know.

Independent Medical Reports

5.52 There are several reasons why an Independent Medical Report (IMR) results in an iCTO. IMRs are usually requested by a patient’s solicitor as a way to challenge the CTO by obtaining a second opinion on the medical reports. While there was agreement that every patient has the right to an IMR, there was concern about motivations for IMRs that were not deemed to be in the patient’s best interest.

“I think it would be a natural position of anyone appearing in a situation faced with two medical reports from two other individuals wanting to detain that person that any person would say, 'I want my own report'. ” (Panel member)

5.53 While some respondents felt a request for an IMR was perfectly reasonable (because it was the only way a solicitor could challenge the CTO on behalf of their client) and felt confident solicitors explained the potential consequences of an IMR (for example, being
detained longer because of it) and would only ask for an IMR if it was in the best interest of the patient, others were concerned that some IMRs are requested for ‘dubious reasons’.

“...on the whole, I think most lawyers are quite good at explaining to people the consequences and what happens if A and B lead to C and all that, you know?” (Advocate)

5.54 There were several examples of solicitors asking for an IMR when it was not required - for example, a hearing to change a CTO from a hospital to community order, which nobody was contesting, but an IMR was still requested. There were also concerns that a patient could be ‘railroaded’ into requesting an IMR, because they trust the advice their solicitor gives them, without fully understanding the reason why they need one or the consequence of getting one - namely, being detained for a longer period.

“I’ve gone to a tribunal with a patient who when I met him was not wanting to oppose it….And the lawyer came in and railroaded him really and said ‘oh well we’ll get an independent report in.’ and, and he didn’t you know he would go with what the last person said.” (Advocacy worker)

5.55 Respondents also wondered why an IMR should be requested when it was clear it would make no difference to the outcome of the CTO application.

“There are some curators that automatically ask for independent psychiatric reports, you know, with patients with very severe dementia – longstanding .. You know, it’s obviously not going to get any better – or somebody with very severe learning disabilities. You wonder ‘Why is the curator asking for an independent psychiatric report’.” (Panel member)

5.56 Solicitors were also criticised for deliberately not getting the IMR in time for the hearing despite having plenty of time to organise one. For example, there were reports that some solicitors may not instruct a psychiatrist to obtain an IMR until days before the hearing, despite knowing the case was a two year review and therefore had plenty of notice of the hearing date.

5.57 The main reason put forward to explain why an IMR may be requested or stalled inappropriately, was a perception of financial gain on the part of solicitors and Curators whom it was felt may ‘spin out’ the tribunal process. The perception was that there is no incentive to have just one hearing; the longer it takes to make a decision, the more money there is to be made from legal aid.

“I am not saying that solicitors deliberately set out to milk a process to increase their revenue from legal aid but there are times when they might.” (MHO)

5.58 Some solicitors representing clients in Highland were also criticised for exploiting the system by not travelling in the most economical way. It was suggested that some will drive from the central belt to a hearing in Highland and back in one day and then do the same the next day rather than stay overnight. Again, financial factors were seen as the primary motivation.

“They’ll come up here two days in a row because I don’t think they get any, they don’t get hotel expenses they only get mileage so they come up here one day, drive
down at heaven knows what time of the night to be back up here for a tribunal at ten o’clock in the morning because the mileage is all paid.”

5.59 However, there are several legitimate reasons why an IMR can result in an iCTO that are outwith solicitors’ control. One of the key reasons why an IMR is not ready for the first hearing is simply because of the short time scales. If the hearing is scheduled at short notice, there often is simply not enough time to meet with the patient and have an IMR ready for the first hearing. There is also the issue of the shortage of psychiatrists (which seem to be more of a problem in Highland than the central belt) to conduct an IMR. Because of the five day period in which the hearing must be held, it will go ahead without the IMR which, in turn, results in an iCTO.

“The patient’s side is entitled to ask for an independent medical report. ...now you have to find a psychiatrist that is willing to do that, has got time to see the patient and write it all up afterwards. And usually between ...an application being made and the first hearing there isn’t time to do that.”

“I think people in this part of the world [Highland] aren’t terribly well served because it’s not easy sometimes to get consultants to come and provide [independent] medical reports.”

5.60 Despite this, there was still a feeling that some solicitors manipulate the system and perhaps do not try as hard as they could to have the IMR ready for the hearing.

“There are times when as an MHO you might be quite frustrated with the solicitor because you might feel that they have actually had plenty of time to organise an independent report being completed and presented you know, and made available. I mean they would no doubt say there are only a finite number of doctors available to do independent reports. And they are all very busy etc etc but...there is a view among the MHOs that there are times when solicitors can you know...how shall I put this? They can extend...push the boundaries big time as to how long a process can take. They can lengthen their involvement a bit sometimes.” (MHO)

5.61 Lack of notice for a hearing can also result in an interim order. For example, if there is not enough time to instruct a solicitor or spend time with an advocacy worker, an interim order is required.

“Sometimes it relates to just maybe wanting to bring other witnesses in or investigate something that the patient has told you. I mean there might be a situation where the patient says to you ‘Well actually, see how they’re saying that? That’s NOT what happened. This is what happened’. And there might be enquiries that you want to make.” (Solicitor)

5.62 Panel members expressed frustration that IMRs were often not presented at the tribunal unless they contradict the medical reports submitted with the CTO application (which they rarely do). However, it was acknowledged that there are no legal powers to insist the reports are ‘tabled’.

“I mean the Solicitors by and large won’t want to lodge them [IMRs] because of course it’s as rare as hen’s teeth for one of these reports to contradict the RMO..... You see the difficulty is that the rules – the statutory instrument, the rules ... which is
not primary legislation – state that if a medical report is obtained, it must be lodged. But nobody... They refuse to do it, and we have no power – short of a specification – to make them lodge it. You know, there's no mechanics for it. And even if we did, there's this huge human rights argument about whether or not you can force someone of necessity to produce evidence which may be prejudicial to them.” (Panel member)

Other reasons for iCTOs

5.63 Some thought panels were more likely to opt for an iCTO in the early days of the tribunal system because there was an incident in which a solicitors’ request for an iCTO was turned down, but was appealed and upheld. Some respondents felt this meant convenors were now more likely to decide to grant an iCTO in order to avoid an appeal. This may explain why the data shows a reduction in the number of CTOs and an increase in iCTOs from October 2006 (see table 4.9).

“I think at one time... Cause there was that directive that was sent round saying... I think it was the one where the lady appealed and won her appeal in the Sheriff's Court. And there was something sent from Hamilton. And I think people were a lot scared of I think 'oh we have to grant an interim order'. But now, I think that most I've been to have been justifiable.” (Advocacy worker)

5.64 Others speculated that panels may grant an iCTO because they lacked the confidence to grant a full order.

“You know, sometimes I get the feeling that that's because they feel that they've not absolutely dotted every I and crossed every T of the Act, and maybe that's about experience or training or something, you know?”

5.65 If a person is unable to attend who would be in a position to give evidence or clarify points and queries, or if information within the application is deemed incomplete (for example, missing information in the application or out of date care plans or medical report), then an interim order may be required.

“It's if somebody hasn’t turned up that you were expecting – that needs to [be there] – that somebody's unwell, that the paperwork isn't properly in order...” (Panel member)

Informants’ suggestions to reduce iCTOs

5.66 Several suggestions were put forward by informants to reduce the number of iCTOs. Again, it should be stressed that these suggestions reflect the views, experiences and perceptions of the research informants:

- The Legal Aid Board could change the fee structure and move away from a ‘time and line’ structure to a fixed fee which includes travel expenses, correspondence costs etc., rather than pay for each separately
- Encourage more lawyers to do mental health work
• Consider increasing the STDO period to allow more time to process the application and obtain an IMR for the first hearing
• Increase the notice period by extending the five day ‘period of grace’ to organise a hearing, therefore allowing more notice and time to prepare and/or obtain an IMR
• Instead of having two medical reports, consider having one medical report and one IMR
• Have a salaried psychiatrist to conduct IMRs quickly
• Increase the pool of psychiatrists to carry out IMRs
• Consider whether solicitors need to organise an IMR, or whether this could be more efficiently arranged by someone else as a specific task
• Consider the merits of a making a paper decision to grant an iCTO if the IMR is not ready.

Efficiency and efficacy of MHTS

5.67 There was a range of opinions relating to questions about the efficiency and efficacy of the MHTS. The difficulty the administration faces organising hearings was acknowledged, and the clerks were praised for their efficiency and ability to run hearings well. However, there were a few reports of people, (mainly Advocacy workers) not receiving notice of a hearing in time or the venue being changed and people not being informed – all of which was frustrating for those involved.

“I’ve turned up at a tribunal that wasn’t happening and it’s like we changed it last week and it’s like well it’s just a complete waste of my time. I have to juggle so many things around in order to make it in two days’ time”. (Advocacy worker)

5.68 There was a feeling, from some respondents, that the system still works fairly ‘manually’- for example, the (perceived) inability to send email rather than paper notification of a hearing (which will hopefully be addressed in light of the current piloting of electronic submission). While most felt the administration had improved since the start of the MHTS, some still felt there was room for improvement – especially in relation to the scheduling of hearings

“I think they’ve certainly got a lot better. To begin with they were terribly rigid they would sometimes insist on things that were wrong and disregarded applications. So they have improved a lot I think the staff feel a lot more comfortable.” (MHO)

Interviewer: Are there any other changes you would recommend?

“Again, it’s just the simple practicalities about the scheduling and .. As I said, although that’s improved, I think there is still some more scope for improvement there – so tiny little changes in terms of the administration of the system.” (RMO)

5.69 There was also a perception that staff turnover was high and morale was low, and that problems between the Chief Executive and the original tribunal President11 created

11 At the time of finalising this report a new President had been appointed.
tension and extra stress on staff. At the time of fieldwork, the administration was missing four managers and were lacking staff to administer the management of statistical information systems. There was, moreover, a feeling that staff could and should be used better.

“I think there should be some sensitivity to morale within the staffing because the staff are absolutely excellent. But if you talk to them, sometimes their morale is low because they're not aware of what is happening at times.” (Panel member).

5.70 Having a separate administration and judicial body was criticised, by some, and was seen to have affected the work of the MHTS - for example, delays in sorting out the number of iCTOs. For some respondents, it was an additional frustration if they need guidance on an issue that affects both the administration and judicial arm of the MHTS, as they have to talk to two different people to get an answer.

“I think it is it was fundamentally wrong to have had a split between the administration and the judicial side…….. We may come across issues to do with the tribunal that cross cut both the administrative and the judicial functions and you almost have to talk, to have two conversations with two separate organisations to try and help try and resolve it.”

5.71 The quality of the MHTS statistics received some criticism. There were also concerns about the ease with which the data held in the MHTS could be interpreted, primarily due to the way initial code was written to extract data from the database when the system was first established (see paragraphs 4.7 to 4.9). While responsibility for this is now an internal function, when a request for data is received, staff must still run the code, check the output and correct the code, which all takes time.

“I mean…basically nobody had been put on the staffing list to do that kind of work so…somebody was contracted through a temping agency, and came in and did stuff and the stuff was all very plausible, and some of it is accurate, but some if it isn’t.”

5.72 There were some concerns about the cost of the MHTS, especially if it is perceived to take resources away from service provision.

“I do worry about the cost of it all, actually taking away money that could be spent on providing services to people rather than this procedure and how much time it takes and I know that the consultants are very, very, very unhappy about the time it takes for them to attend.” (MHO)

**Improving MHTS**

5.73 We asked the research respondents how MHTS might be improved. Several suggestions were put forward. Once again, it is important to bear in mind that their suggestions reflect their views, experiences and perceptions:

- Training sessions could be condensed
- Better planning of panel members time, especially in Highland
• Merge the MHTS with all Scottish tribunals into one Headquarters, which would give staff more opportunities, venues could be shared and therefore be closer to where people live, and better use would be made of clerk and clerk assistant time

• Involve advocacy workers earlier on in discussions around the need for a CTO as they might encourage the patient to take treatment voluntarily and negate the need for a CTO

• Leaflets need to be interpreted into more than six languages

• Consider whether variations to CTOs need to be heard at a hearing, can they be dealt with more efficiently by paper?

Key points

• Writing a CTO application varied, depending on the case, but was around two to three days. Practical difficulties, such as typing the form and problems around electronic submission make the application process more time consuming than it should be.

• Late submission of a CTO application means short notice of a hearing date which creates problems for those attending, e.g. RMOs having to cancel clinics/patient appointments or solicitors not having enough time to prepare their case, which can result in an iCTO.

• Encouraging MHOs to submit a CTO application earlier on in the STDO (to enable a longer hearing notices period) was not seen as appropriate as it is in the patient’s best interest to wait until nearer the end of the 28 days to see if their condition has improved.

• Panel members download hearing papers on their home PCs, none could recall any guidance on data protection. There have been occasions where hearing papers have been taken down before the hearing, causing inconvenience for the panel members as they have to call and ask for them to be put back on.

• Hearing duration depends on who is present, e.g. comfort breaks for the patient, the type of convenor – some keep things focused and short, others ‘get bogged down in detail’, and the type of order sought.

• The new tribunal system was praised for being fairer, more open, and accountable and ‘patient focused’ than the old Sheriff Court system. But it can be upsetting for patients to hear their personal case histories told to strangers and are unable to articulate their point of view.

• There was concern around some of the venues used as they were deemed unsuitable due to lack of waiting rooms or private rooms for the patient to talk to their Solicitor or advocacy worker.

• There was general agreement that iCTOs are higher than anticipated but there was no clear consensus around whether this was problematic or not.

• The main reasons for iCTOs were a convoluted process to appoint a Curator Ad Litem (which has now been resolved) and the need to obtain an Independent Medical Report (IMR).

• There was general agreement that it is every patient’s right to request a second opinion via an IMR but there was concern that its use can sometimes be for ‘dubious reasons’, e.g. used as stalling tactics by some solicitors for their own financial gain.

• Several suggestions were put forward by respondents to reduce the number of iCTOs:
The Legal Aid Board should change the fee structure and move away from a ‘time and line’ structure to a fixed fee which includes travel expenses, correspondence costs etc., rather than pay for each separately as they do at present.

- Pay lawyers by case not per hearing
- Encourage more lawyers to do mental health work
- Consider increasing the STDO period to allow more time to process the application and obtain an IMR for the first hearing
- Increase the notice period by extending the five day ‘period of grace’ to organise a hearing, therefore allowing more notice and time to prepare and/or obtain an IMR
- Instead of having two medical reports consider having one medical report and one IMR
- Have salaried psychiatrist to do IMRs quickly
- Increase the pool of psychiatrists to do IMRs
- Consider whether solicitors need to organise an IMR, could this be more efficient if it was given to someone else as a specific task?
- Consider the merits of a making a paper decision to grant an iCTO if the IMR is not ready.
CHAPTER SIX  MHTS COSTS

6.1 This chapter explores the range of costs associated with the MHTS process. These include costs covered by MHTS Administration (MHTSA) – for example, clerical and administration; panel members; Hearing Clerks and Venue Assistants. We also examine legal representation costs for people detained under the act, using data from the Scottish Legal Aid Board (SLAB) and discuss costs for local authorities and Health boards.

6.2 An important distinction between this stage of the research and the previous stages is that our analysis here looks at all costs associated with hearings under the MHSA and not just CTOs as in the previous stages. The main reason for this is that cost data available to us was not split by type of order sought. This means that compulsion and restriction orders (i.e. Shrieval hearings) have also been included.

6.3 We begin our analysis by presenting individual costs incurred by MHTSA, SLAB, local authorities and Health boards. We then use this information to look at the overall MHTS process cost for the 2006-07 financial year, and conclude with a discussion of the cost of an individual hearing.

MHTS Administration total costs for 2006-2007

6.4 Despite the MHTS consisting of two parts (the Administration and the Tribunal) all costs associated with the MHTS are covered by one budget; the MHTS Administration budget (here in referred to as MHTSA). The MHTSA divide their costs into two main areas - Tribunal costs and Administration costs. Tribunal costs relate to anything connected with running a hearing and include Panel Member fees, expenses, training, and the cost of security at hearings venues. Administration costs are associated with running the office in Hamilton and include, for example, staff costs, IT equipment, and office expenses.

6.5 MHTSA costs were obtained from the 2006-07 annual accounts, and supplemented with additional information from the MHTSA finance and Senior Management teams. The most recent financial accounts for 2007-08 were, unfortunately, not available within the study timeframe so the previous year’s accounts have been used instead.

6.6 Tables 6.1 and 6.2 present the full range of MHTSA costs, separated into Tribunal and Administration costs, and show a total cost of £8,301,000 for 2006-07. It should be remembered that these are costs for the full range of hearings conducted under the MHSA 2003 and not just for CTO applications, which have been the main focus of this report.

6.7 Tribunal costs – that is, hearing costs were £5,650,200 for 2006-07, with MHTS Administration costing £2,650,800\(^\text{12}\).

6.8 The greatest cost incurred by the MHTSA was Panel Member fees which at £4.35 million accounted for over 50% of the total expenditure. The fees for panel members were higher than expected, as they suggest that none of the 3,599 hearings were ‘doubled up’ i.e. two hearings by the same panel on one day. However, this may be due to the fact that panel

\(^{12}\) Excludes cost of capital utilised by MHTS which is £5,000 credit and is based on the rate set by HM Treasury (3.5%) on the average carrying amount of net assets and liabilities.
members were paid a daily rate for attending their initial training sessions. The next highest expenditure at £1.18 million was MHTSA permanent staff (14% of the total expenditure). In 2006-07 a further £384,000 was spent on agency staff which, at the beginning of the financial year, related to 22 (full-time equivalent) agency staff but had reduced to four by the end of March 2007, with an average of 10 agency staff employed across the 12 months. The highest office–related expenditure was for postage, courier and telecoms costs, at a total cost of £236,000.

6.9 Figures that seem particularly low were the £3,200 for hospitality at venues and the £251 (figure for 2007-08) for translation costs. The low level of these figures could suggest that these costs may be incurred by other organisations, such as local authorities or health boards.

Table 6.1   Tribunal costs for 2006-2007

<table>
<thead>
<tr>
<th>Tribunal Costs</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Panel Members</strong></td>
<td></td>
</tr>
<tr>
<td>Fees</td>
<td>£4,352,000(^{13})</td>
</tr>
<tr>
<td>Expenses</td>
<td>£317,000</td>
</tr>
<tr>
<td>Social security</td>
<td>£312,000</td>
</tr>
<tr>
<td>Presidents' pension</td>
<td>£64,000</td>
</tr>
<tr>
<td>(future liability not a cost paid out)</td>
<td></td>
</tr>
<tr>
<td>Members' training</td>
<td>£58,000</td>
</tr>
<tr>
<td><strong>Other staff</strong></td>
<td></td>
</tr>
<tr>
<td>Hearing clerks - wages &amp; expenses</td>
<td>£0</td>
</tr>
<tr>
<td>(Figure included under MHTSA staff costs – total Hearing clerks costs including wages, expenses, training, pension = £900,000)</td>
<td></td>
</tr>
<tr>
<td>Security staff - wages &amp; expenses</td>
<td>£297,000</td>
</tr>
<tr>
<td>Man of Skill</td>
<td>£247,000</td>
</tr>
<tr>
<td>Translators</td>
<td>£0</td>
</tr>
<tr>
<td>(For 2007-08 = £251)</td>
<td></td>
</tr>
<tr>
<td><strong>Other attendees</strong></td>
<td></td>
</tr>
<tr>
<td>Named Person – expenses</td>
<td>Not known</td>
</tr>
<tr>
<td><strong>Venue</strong></td>
<td></td>
</tr>
<tr>
<td>Hospitality</td>
<td>£3,200</td>
</tr>
<tr>
<td><strong>Total Tribunal costs</strong></td>
<td>£5,650,200</td>
</tr>
</tbody>
</table>

\(^{13}\) This figure is different to what appears in the 2007 Annual Accounts, which recorded Panel Members’ fees as £3,446,000 and social security costs of £1,535,000, giving a total of £4,981,000. Although the total is correct, after seeking clarification from MHTS, we discovered that the balance between the Panel Members’ fees and social security costs should have been £4,352,000 for Panel Members’ fees and £312,000 for social security for Panel Members, which we have added to table 6.1. An amendment to this effect will appear in the 2008 Annual Accounts.
### Table 6.2 Administration costs for 2006-2007

<table>
<thead>
<tr>
<th>Administration Costs</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MHTSA Staff</strong></td>
<td></td>
</tr>
<tr>
<td>All permanent MHTSA staff (inc. hearing clerks)</td>
<td>£1,185,000</td>
</tr>
<tr>
<td><strong>Agency staff</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>£384,000</td>
</tr>
<tr>
<td><strong>Pension</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>£194,000</td>
</tr>
<tr>
<td><strong>Social Security</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>£91,000</td>
</tr>
<tr>
<td><strong>Training</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>£29,000</td>
</tr>
<tr>
<td><strong>Office Costs</strong></td>
<td></td>
</tr>
<tr>
<td>Postage, courier, telecoms</td>
<td>£236,000</td>
</tr>
<tr>
<td>Transport (travel expenses for MHTSA staff)</td>
<td>£154,000</td>
</tr>
<tr>
<td>Accommodation (cost of Hamilton office)</td>
<td>£224,000</td>
</tr>
<tr>
<td>Office expenses</td>
<td></td>
</tr>
<tr>
<td>Includes: computer system support costs billed by NHS ISD for the central computer system and services; computer equipment and software not able to be capitalised; stationery; office equipment maintenance; hospitality; advertising; and other general miscellaneous expenditure.</td>
<td>£119,800</td>
</tr>
<tr>
<td>External audit (cost of Audit Scotland)</td>
<td>£28,000</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td></td>
</tr>
<tr>
<td></td>
<td>£6,000</td>
</tr>
<tr>
<td><strong>Total Administration costs</strong></td>
<td>£2,650,800</td>
</tr>
</tbody>
</table>

### Legal costs for 2006-2007

6.10 Legal costs associated with providing advice and representation for patients in relation to the MHSA are paid by the Scottish Legal Aid Board. The SLAB annual report for the year 2006/07, as well as discussion with relevant SLAB personnel have been used to generate legal costs.

6.11 Legal Aid entitles people to ‘advice and assistance’ which means they will receive advice from a solicitor, and can also have solicitor representation at a CTO hearing paid through ABWOR (assistance by way of representation). SLAB annual report records both separately (i.e. advice and assistance only and ABWOR). However, discussion with SLAB suggests that there is some confusion from solicitors as to whether they should be claiming for A&A or ABWOR. For example, some claim for A&A and then ABWOR whereas others claim for ABWOR only, so from a recording point of view there is some blurring of each.
We have therefore combined the figures when reporting costs in the text but have listed A&A and ABWOR separately in table 6.3. It should also be noted that costs associated with ABWOR are for representation at a Tribunal hearing, only. However, A&A includes a wide range of advice relating to the MHSA, which is not necessarily related to the tribunal process. In addition, the number of cases figure in table 6.3 should be read with caution, as there is a degree of uncertainty over what constitutes a ‘case’. For example, the number of cases reflects the costs paid out under different Legal Aid references; however, the same patient may have more than one case reference and some of the cases that appear under ABWOR were also given assistance and advice.

6.12 Top line figures from the Annual Report 2006-07 show that the total number of mental health cases that required legal aid (and therefore legal representation) was 2,115 at a cost of just under two million pounds (£1,997,000). It is important to note that SLAB do not have separate codes for legal aid applications for different parts of the MHSA. This means that figures in table 6.3 are for all work conducted under the MHSA for civil legal assistance and are not separate costs for CTOs only.

<table>
<thead>
<tr>
<th>Type of legal help</th>
<th>Number of cases</th>
<th>Payments to solicitor</th>
<th>Outlay payments</th>
<th>Total payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Civil assistance and advice</td>
<td>1120</td>
<td>£779,000</td>
<td>£280,000</td>
<td>£1,059,000</td>
</tr>
<tr>
<td>Civil ABWOR</td>
<td>995</td>
<td>£710,000</td>
<td>£228,000</td>
<td>£938,000</td>
</tr>
<tr>
<td>Total</td>
<td>2115</td>
<td>£1,489,000</td>
<td>£508,000</td>
<td>£1,997,000</td>
</tr>
</tbody>
</table>

6.13 The total SLAB cost for 2006/07 was 20% higher than the previous year (2005/06), when the comparable figure was £1,590,000. Interestingly, however, the average cost per case dropped by 5%, from £1000 in 2005/06 to £947 in 2006/07.

**Individual component costs**

6.14 We have seen the total costs incurred by SLAB, but what individual costs contribute to the overall spend? When solicitors submit an invoice to SLAB, it is broken down to include all component costs, e.g. travel time, mileage, letters, number of meetings etc. Unfortunately each component cost is not recorded electronically – only the total claim amount. However, we were able to obtain a monetary value of individual component costs solicitors can claim from SLAB which are listed below and have also been fed into the costs estimating spreadsheet.
<table>
<thead>
<tr>
<th>Table 6.4  Individual component costs that solicitors can claim from SLAB</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time engaged in meetings, perusals, travel, waiting &amp; preparation</strong></td>
</tr>
<tr>
<td>Per quarter hour</td>
</tr>
<tr>
<td><strong>Precognitions</strong></td>
</tr>
<tr>
<td>Per page based on 250 words</td>
</tr>
<tr>
<td>Per 1/2 page</td>
</tr>
<tr>
<td><strong>Letters</strong></td>
</tr>
<tr>
<td>Non-formal letters (based on 125 words) per page</td>
</tr>
<tr>
<td>Formal letters</td>
</tr>
<tr>
<td><strong>Telephone calls</strong></td>
</tr>
<tr>
<td>Up to 4 mins</td>
</tr>
<tr>
<td>5 - 10 mins</td>
</tr>
<tr>
<td>Over 10 mins (per quarter hour)</td>
</tr>
<tr>
<td><strong>Framing formal documents</strong></td>
</tr>
<tr>
<td>Per page (based on 250 words)</td>
</tr>
<tr>
<td><strong>Conducting Tribunal</strong></td>
</tr>
<tr>
<td>First half hour</td>
</tr>
<tr>
<td>Each quarter hour thereafter</td>
</tr>
<tr>
<td><strong>Mileage</strong></td>
</tr>
<tr>
<td>Per mile (excluding VAT)</td>
</tr>
</tbody>
</table>
Health Board and Local Authority costs

6.15 In recognition that to successfully implement the act, improvements are needed in mental health services, the Scottish Government gives an annual grant to local authorities, which is currently £13 million. In particular it was recognised that an increase in the number of MHOs and independent advocacy services would be required. Each local authority has the autonomy to decide the best allocation of these funds to meet local needs. However, there is no requirement to record how the money is spent specifically on the MHTS and it is therefore not possible to know how much of it is used for the tribunal process and how much for other aspects of the Mental Health Act. This means that our estimates are an under representation of the true costs.

6.16 People we spoke to found it relatively easy to list the costs they perceived as being part of the MHTS process (listed below), but found it difficult to give an accurate monetary value for these costs. The main reason for this is because MHTS costs incurred by health board and local authorities do not appear to be recorded separately, so the information cannot easily be obtained. Some health boards and local authority staff spoke to colleagues to give a rough estimate of costs, and these have been incorporated into a separate spreadsheet as sample costs (see paragraph 6.31 for more detail).

6.17 Perhaps a reason why these costs are not recorded is because many are subsumed within health board and local authority budgets - probably part-funded through the yearly budget they receive to implement the MHSA - and are not separated out so it is impossible to know a true monetary value for the MHTS process. As a result, we are unable to give an accurate idea of MHTS process costs incurred by health boards and local authorities for 2006-07, but can instead discuss the perceived costs incurred by local authorities and health boards as part of the MHTS process.

- **Escort costs** – sometimes health board or local authority staff will arrange transport for a patient to attend a hearing, incurring a cost paid out by the health board or local authority. There can also be costs for hearings in the community, e.g. patients may claim for transport costs to attend a hearing or, sometimes, staff will collect them meaning costs for mileage and travel time. For hospital based hearings patients can be escorted by a nurse who usually stays for the whole hearing, implying an indirect cost as they are taken off the hospital ward.
- **Mileage costs** – cost per mile ranged from 40-53 pence for MHOs and RMOs, and can include costs to attend a hearing, deliver paperwork to the Administration in Hamilton and visit the patient. Not surprisingly, mileage was higher in Highland with one MHO having to make a 240 mile round trip to see one client.
- **Car parking charges to attend a hearing and visit patients**
- **Venue and refreshments costs** – These are usually covered by the health board or local authority, but some claim the cost from MHTSA.
- **Council Solicitors (who represent an MHO at a hearing and are not often used)** – This does not appear to be recorded as a separate MHTS cost because they are employed to represent social work so do this as part of their job.
- **Interpreter costs** – although not required often this was perceived to be paid for either by the local authority or health board.
One cost that we are able to provide relates to the time spent on the CTO process by RMOs, MHOs and medical records staff. Figures for the time spent on CTOs were provided through the research by Atkinson et al (2007)\(^{14}\). Time costs for RMOs are based on the time spent on the CTO application and on the operation of a CTO which is defined as: preparing and implementing care plans and informing patients of finalised care plans. This was deemed to be within the scope of the CTO process discussed throughout the report. Time spent on each application and operation of a CTO were:

- MHOs – 992 minutes
- RMOs – 345 minutes
- Medical records staff – 48 minutes

A monetary value, based on the time spent by RMOs, MHOs and medical records staff was calculated, in Atkinson et al, based on their salary, salary on costs (national insurance and superannuation) and overheads. It has been possible to update these figures for 2006-07 to include them in the average hearing costs.

The RMO figure in Atkinson et al was taken from the PSSRU Unit Costs\(^{15}\) published by Kent University every year. For Consultant Psychiatrists, the PSSRU Unit Costs provide an hourly rate and a patient-related hourly rate, the lower figure of the hourly rate has been used for our calculations. For MHOs and medical records staff, Atkinson et al provided an average annual salary cost in Scotland, these figures have been updated by RPI (4.4% in 2006-07) (and then converted into an hourly rate. The hourly rate is converted into a rate per minute (£1.92 for RMOs, £0.50 for MHOs, £0.32 for medical records staff), as the time spent on CTOs was originally expressed in minutes, and from this a cost per case is calculated. This is then used to calculate an annual cost for RMOs, MHOs and medical records staff by taking the cost per case, dividing it by the average number of hearings per case, 1.7, and multiplying it by the total number of hearings in 2006-07, 3,599.)

The annual costs associated with the time spent on the CTO process were:

- RMOs: £1,403,610
- MHOs: £1,050,908
- Medical records staff: £32,391\(^{16}\)

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\(^{16}\) This figure appears low in relation to the annual costs for RMOs and MHOs. This is due to the fact that the time spent by medical records staff, as recorded in Atkinson et al, is only 48 minutes on each CTO application and their cost per minute is only £0.32.
Overall cost of the MHTS process 2006-2007

6.22 Having outlined separate costs for the MHTSA, Tribunal, SLAB and to a lesser extent health boards and local authorities, we can now give an informed idea of the total cost of the MHTS process for 2006-07, which we estimate at £12,784,909\(^{17}\). For reasons already discussed, this does not include the £13 million grant to local authorities from the Scottish Government to cover implementation costs of the Mental Health Act.

Costs per hearing

6.23 Having estimated the total cost of the MHTS process for 2006-2007, we turn now to estimate the average cost of hearing.

6.24 The MHTSA calculated a projected cost for an individual hearing for 2008-09 of £1,460. However, this is based on panel member costs only (i.e. fees for the three Panel Members, employer national insurance contributions (NICs) and expenses) and does not include Legal and MHTSA costs (i.e. case processing, setting up hearings etc.). A breakdown of this cost is shown below in table 6.5.

<table>
<thead>
<tr>
<th>Cost</th>
<th>Calculation</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal Panel Member</td>
<td>Daily fee</td>
<td>£430</td>
</tr>
<tr>
<td>Medical Panel Member</td>
<td>Daily fee</td>
<td>£387</td>
</tr>
<tr>
<td>General Panel Member</td>
<td>Daily fee</td>
<td>£387</td>
</tr>
<tr>
<td>Employer NICs</td>
<td>12.8% of fees (£1204)</td>
<td>£154</td>
</tr>
<tr>
<td>Expenses</td>
<td>Average cost per hearing</td>
<td>£100</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>£1460(^*)</strong></td>
</tr>
</tbody>
</table>

\(*\)Figure rounded to nearest 10.

6.25 In order to produce an average cost per hearing that incorporates all known costs associated with the hearing process, and not just direct costs paid out by MHTSA, an excel spreadsheet was created. This includes all the component costs mentioned above and computed a cost at an individual hearing level, by dividing the total costs by the number of hearings for 2006-07 (3,599\(^{18}\)).

6.26 Before we present the average cost of a hearing there are various caveats which should be considered when reviewing the findings and/or using the spreadsheet (which can be accessed via the Scottish Government). These are discussed below in no particular order.

\(^{17}\)This is the total of MHTS costs (£8,301,000), SLAB costs (£1,997,000) and time costs for RMOs, MHOs and medical records staff (£2,486,909).

6.27 First, there is no such thing as a typical hearing, in fact the cost for an individual hearing will vary greatly in relation to both direct and indirect costs. Factors that will influence direct costs include:

- distance travelled to hearing by panel members and other attendees, for example patients, MHOs, solicitors
- amount of time spent preparing for a hearing for RMOs, MHOs, solicitors, advocacy workers etc
- the length of the hearing
- whether the panel members were able to attend two hearings in one day (as they are paid a daily rate, not per hearing)
- expenses required by a Named Person.

6.28 Factors that will influence the average cost of a hearing in relation to indirect costs are:

- time spent by MHTSA staff on:
  - dealing with an application
  - setting up a hearing
- whether there is more than one hearing per application
- courier and postage costs for MHTSA, health boards or local authorities e.g. if electronic transfer of documents is available this reduces costs

6.29 Secondly, in developing the costs for a hearing, consideration has been given to MHTSA costs, SLAB costs and those costs associated with local authorities and health boards. As has been shown in paragraph 6.16, many of the costs relating to mental health tribunals covered by local authorities and health boards are not recorded separately and figures are not available.

6.30 As a typical hearing does not exist, we developed an average cost, by taking total cost figures and dividing them by the number of hearings that were held in 2006-07 (3,599). In dividing the costs equally, the figure per hearing assumes, for example, that the same time was spent on each hearing, the same travel costs were incurred etc. In order to provide consistent costs, even though a lawyer and a Man of Skill are not involved in every case or hearing, the average cost per hearing for them has been calculated in the same way, by dividing the annual costs with the total number of hearings, 3,599.

- The average time costs for RMOs, MHOs and Medical Records staff were calculated by taking the average cost per case and dividing this by the average number of hearings per case, 1.7 (for details on how the average cost per case was calculated see paragraph 6.25 above).

6.31 The spreadsheet that was developed to calculate the above costs also provides a tool that allows the cost of a specific hearing, or a hypothetical hearing, to be calculated. The impact of the variation of specific costs can be calculated and the differences between specific scenarios can be compared. The sheet includes values fixed at the national level (for example, MHTSA staff costs), but all variable costs can be entered by the user. An accompanying sample rates sheet provides examples of different types of costs collected from local authorities, health boards and SLAB. For example, mileage rates for some health boards and local authorities and the range of fees that are available to solicitors through SLAB are also itemised.
6.32 Taking cognisance of the above, we have estimated the average cost for a hearing in 2006-07 as £3,774. This figure includes all MHTSA costs, including an average cost for Man of Skill (see paragraph 6.30); SLAB costs, which incorporate IMR costs; time spent by RMOs, MHOs and medical records staff, but does not include any further costs covered by local authorities and health boards (see paragraphs 6.16 & 6.17 for further details). As it is not clear how the £13 million annual grant paid to local authorities is spent (see paragraph 6.15 for details) this has been excluded from the calculations. However, the average cost per hearing could be up to twice as much, £7,386, if this grant were to be included in the calculations.

Key points

- Total costs for all MHTS related activity in 2006-07 are estimated at £12,784,909. This includes all MHTS Administration costs, SLAB costs and time costs associated with RMOs, MHOs and medical records staff.
- MHTS Administration costs accounted for £8,301,000, with Panel Member’s fees being their highest cost accounting for more than 50% of the total.
- Total SLAB costs were £1,997,000 which includes the cost of solicitors’ time and expenses, independent medical reports and curators.
- Many of the costs incurred by local authorities and health boards relating to mental health tribunals are subsumed within existing budgets and therefore it is not possible to provide any accurate figures for how much they spend on tribunal related activities. It is likely that some of the annual grant of £13 million, given to local authorities to improve mental health services and help implement the MHSA 2003, is used to fund costs directly associated with mental health tribunals.
- The type of costs that local authorities and health boards incur are:
  - Escort costs – for LA and HB staff to accompany patients to hearings
  - Mileage and parking costs – for MHOs and RMOs to visit patients, attend hearings or deliver paperwork
  - Venue and refreshment costs
  - Council solicitors – where a solicitor is needed to represent the interests of the MHO at a hearing
  - Social workers – time spent giving evidence at a hearing
- The time spent by RMOs, MHOs and medical records staff is estimated to have cost £2,486,909 in 2006-07.
- The average cost per hearing is estimated at £3,774. This includes the following costs: MHTS Administration, Man of Skill, SLAB, independent medical reports, time spent by RMOs, MHOs and medical records staff but no further costs covered by local authorities or health boards.
CHAPTER SEVEN CONCLUSIONS & RECOMMENDATIONS

The overall aim of the research was to explore the detailed operation of the MHTS, with a specific focus on processes that are perceived to have increased the number of interim compulsory treatment orders. In order to address this overarching aim, five specific objectives were outlined by the commissioning team. The starting point for this chapter will be to re-visit these objectives, to draw together the evidence from all three strands of the research, and to put forward conclusions. The chapter will then present recommendations for the future development of the MHTS process, which can inform the review of the MHSA.

The operation and impact of the MHTS, in practice, from the perspectives of all relevant stakeholder groups.

There was consensus that the new system had improved patients’ experiences, and reflected the guiding principles, by being:

- Fairer for patients than the Sheriff Court system
- More ‘patient focused’ - it was deemed friendly, open and accountable
- More participatory, allowing patients to feel that they were listened to (even if they do not agree with the final decision) and to have a voice.

However, there were concerns that:

- It can be very upsetting for patients and families to hear the evidence presented and have their mental ill health discussed in front of strangers.
- The new system may have a damaging impact on the therapeutic relationship between a patient and their psychiatrist/MHO, especially if they are giving evidence to support a CTO that the patient does not want.
- Some venues were criticised as being inappropriate for hearings - for example, insufficient or non-existent, private space for families and for patients to talk to their solicitor.

The data collected for administrative purposes by MHTS and local authorities and health boards may not be wholly adequate for a wider monitoring and audit function. In particular, the format of data processing with uncoded free text entered in PDF format, inhibited certain analyses which may be useful – for example, by diagnostic category.

The input and impact of the range of participants who may be involved in each MHTS hearing

The participation of the range of people other than panel members who may be required or may wish to attend a hearing (including the MHO, the RMO, solicitors, Advocates, Named Persons, social workers, CPNs and patients themselves) is affected by the sometimes short notice of hearings.
The processes involved in making a civil order under MHSA which may be contributing towards the high level of interim orders and multiple hearings.

In general, respondents tended to support the view that the number of iCTOs was high, but it was apparent that this was seen, to some extent, as an inevitable consequence of the new patient-centred system. Despite this, a number of suggestions were made to explain why so many iCTOs were granted. The most common reasons cited were:

- The need to appoint a Curator Ad Litem (which has since been resolved)
- Requests for an Independent Medical Report (IMR) which it may not be possible to conduct in time.

While there was general agreement that it is every patient’s right to request a second opinion via an IMR, there were concerns that its use can sometimes be for ‘dubious reasons’, including suggestions that some solicitors may use the IMR as a stalling tactics for their own financial gain. However, it was also clear that there were several “legitimate” reasons that were outwith solicitors’ control why - within the context of the requirement to hold a hearing within a short time period, - an IMR cannot be conducted in time and may result in an iCTO. These include late notice of a hearing where there is no time to organise an IMR in advance, and a shortage of psychiatrists (which seem to be more of a problem in Highland than the central belt) to conduct an IMR.

There were also concerns that the electronic submission of applications was hampered on the one hand by a lack of knowledge that this facility was available and, on the other hand, by technical difficulties associated with electronic submission.

The administrative processes may also be hampered by the often late arrival of CTO applications within the 28 day STDO period, leaving little time to fulfil the MHSA stipulation for hearings to be convened with five days of a STDO expiring.

External factors which may be affecting the efficacy or efficiency of MHTS processes.

The main external factors identified by respondents was the need to work within the constraints of the Act. In particular, the timing of hearings within a narrow window and the sometimes compounding influence of late submissions.

The costs of the MHTS system, in total and on an individual case and hearing basis.

- The total audited costs for MHTS-related activity in 2006-07 are estimated at £12,784,909. This includes all MHTS administration costs, SLAB costs and known costs associated for the time of RMOs, MHOs and medical records staff. MHTS Administration costs accounted for £8,301,000, with Panel Members’ fees accounting for more than 50% of the total. Total SLAB costs were £1,997,000 which includes the cost of solicitors’ time and expenses, independent medical reports and curators. Many of the costs incurred by local authorities and health boards relating to mental health tribunals are subsumed within existing budgets and, therefore, it was not possible to provide any accurate figures for how much they spend on tribunal related
activities. However, local authorities currently receive an annual grant of £13 million to improve mental health services and help implement the MHSA 2003. As the precise allocation of these funds is not known and cannot be attributed to defined areas of work (be they capital or recurrent), they are not reflected in the figures presented here.

The average cost per hearing is estimated at £3,774. This includes the costs for MHTS Administration, Man of Skill, SLAB, independent medical reports, time spent by RMOs, MHOs and medical records staff but no further costs covered by local authorities or health boards. However, if the grants to local authorities and health boards are included, then the actual cost per hearing is almost certainly considerably greater.

**Recommendations**

The research informants made a number of suggestions about how the MHTS might be improved. We believe there is a greater utility in working with key groups to consider whether and how perceived deficiencies might be addressed and changes to practice might be incorporated and are, therefore, wary of presenting these as recommendations per se.

Throughout the rest of this chapter we will highlight the possible changes and revisions to practice which flow from the findings, drawing on the observations and insights of the informants both within interviews and group discussions, but also from the System Mapping Event. The System Mapping Event deliberations are also presented in a stand-alone document which was sent to participants (see appendix H).

**Improving systems for monitoring and audit**

- Ensure that the data are processed in a format that allows statistical analysis of key variables in relation to information that is not currently accessible in a format for statistical analysis, such as diagnosis
- If a more informed picture of health board and local authority costs are required, there is a need to develop systems for recording time and costs associated with Tribunals

**Improving systems for the submission and processing of CTO applications**

- Revision of the application form to make it more user-friendly and to avoid repetition
- Improve mechanisms for submission, particularly so that applications can be submitted by email, ensuring that all relevant parties are aware that they can submit electronically
- Pre-tribunal preparation and screening by MHTS to facilitate earlier identification of errors or omissions, or the need for a Curator Ad Litem, legal representation and an independent medical report
- Consider whether variations to CTO need to be heard at a hearing or whether that can they be dealt with more efficiently by paper
- Where an appeal is lodged against a CTO, the papers from the original application should be made available to the appeal Tribunal. The report for that hearing should then describe the case history since the last hearing/decision.
Specific roles

- Involve Advocacy workers earlier on in discussions around the need for a CTO as they might encourage the patient to take treatment voluntarily and negate the need for a CTO.
- The appointment of the Curator Ad Litem before the first hearing could reduce the number of interim orders and reduce costs, time and effort, but requires a decision about who has the financial responsibility for the appointment.

Dealing with the consequences of the legal / evidential nature of the tribunals

Consider ways in which the possible negative impact on the therapeutic relationship of legal requirements to cross examine might be minimised, including:

- Avoidance of repeated oral hearings in which the reasons for a patient’s detention are reiterated.
- Replace RMOs’ full reports with a brief statement indicating that each of the 5 criteria have been met. (The RMO is present for the hearing and so could elaborate if necessary).
- Consider whether all patients coming to Tribunal should routinely have an independent medical opinion. The increase in efficiency and reduction in interim treatment orders would more than compensate for the increased report-writing.

Training

Some of the actors in the MHTS process may contribute to delays or confusion because they do not fully understand the law or complete the forms as intended. There is a need, in the first instance to:

- Review the training that is available and its take-up, both for those coming new to the process and as a ‘refresher’
- Consider ways in which understanding the roles and perspectives of other participants might be facilitated
- Improve understanding of the role of the Named Person
- Increase number of MHOs, particularly in geographically widespread areas; and political commitment to organise and pay for out-of-hours MHO cover
- Address the real deficit, particularly in rural areas, in the number of lawyers skilled and enthusiastic to represent clients at Tribunals and psychiatrists to conduct IMRs
- There is a need to encourage a greater number of lawyers to undertake mental health work and to provide training as part of that process
- Increase efforts to recruit and train more members of the public, service users and carers to be panel members

The Act and MHTS

Finally in relation to the terms of the Act itself and its administration:
• There were suggestions that the number of applications for CTOs could be significantly reduced if the duration of the STDO was increased to 42 days to allow improvements to patients’ response to treatment to become manifest, or
• Consider extending the five day period of grace to give the administration more time to process the application and organise a hearing, and therefore, address the problems associated with the current short notice for hearings.
• Merge the MHTS with all Scottish tribunals into one body. This could enhance staff opportunities, venues could be shared and therefore be closer to where people live, and better use would be made of clerk and clerk assistant time.
GLOSSARY OF TERMS

Advocacy workers: under the Act anyone with a mental health problem has the right to access an independent advocacy worker. An advocacy worker is able to give support and help to enable a person to express their own views about their care and treatment.

Case: A case refers to a CTO application and includes all hearings associated with this application. Therefore, a case may include several hearings.

CPN: Community Psychiatric Nurse

CMS: Case Management System, the database used by MHTS to assist in processing applications and arranging hearings.

CRN: Case Reference Number is a unique reference generated by MHTS for every new application and used for all correspondence and linking data together.

CTO: Compulsory Treatment Order. Introduced under the MHSA in 2003 the order allows people with mental health problems to receive compulsory treatment either in hospital or in the community. If a CTO is granted, it can last for up to six months initially. It can then be extended for a further six months, then for periods of 12 months at a time.

Curator Ad Litem: A Curator Ad Litem is appointed when a patient is deemed incapable of understanding the CTO process and making decisions themselves. The Curator’s role is to act in the patient’s best interest.

Interim CTO: This can be granted pending a final decision on whether to grant a CTO. It can last for up to 28 days. When the interim CTO runs out of time, the Tribunal can make another interim CTO, so long as the total time someone is on an interim CTOs is not more than 56 days.

Man of Skill: a Man of Skill ascertains whether a Curator Ad Litem is required for a specific patient.

Mental Welfare Commission: The Mental Welfare Commission is an independent organisation. Its role is to protect the welfare of people who are vulnerable through mental disorder.

MHO: Mental Health Officer, a specialist social worker in Scotland who works exclusively on mental health cases and has special responsibilities under the Mental Health (Scotland) Act 2003.

MHSA: Mental Health (Care and Treatment) (Scotland) Act 2003

MHTS: Mental Health Tribunal for Scotland

MHTSA: Mental Health Tribunal for Scotland Administration. Responsible for carrying out the administrative functions of the Tribunal e.g. case management and scheduling Tribunal hearings. Based at Hamilton and staffed by Scottish Government civil servants.
**Named person:** Someone who will look after the patient’s interests if he or she has to be treated under the Act. They are sent the full application form and are invited to attend any hearings.

**Patient:** The term patient is used in this report to describe anybody who is subject to a CTO application or a CTO order.

**PIN:** Patient Identification Number (PIN) allocated to individual patients by MHTS, used to link different cases or applications that relate to the same individual.

**RMO:** Responsible Medical Officer, usually a consultant psychiatrist who is responsible for the patient’s care and treatment. They write the first medical report and attend the hearing to give evidence in support of the application.

**SLAB:** Scottish Legal Aid Board provide funding for solicitors advising and representing patients, named persons and other interested parties in the tribunal process.

**STDO:** Short-term Detention Order, also known as a STDC: Short-Term Detention Certificate. This is the order that usually precedes a CTO application and can last up to 28 days.

**NatCen:** National Centre for Social Research

**ScotCen:** Scottish Centre for Social Research

**Webroster:** A software programme used by MHTS to coordinate hearings including allocating a suitable date and venue and providing Panel Members and hearings staff.
REFERENCES


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LIST OF APPENDICES

Appendix A – List of data requested from MHTSA
Appendix B – Stakeholder topic guide case study areas
Appendix C - Stakeholder topic guide national perspective
Appendix D – Topic guide for mini focus groups
Appendix E – Research Information Leaflet
Appendix F – Thematic Chart Example
Appendix G – System Mapping Workshop Invitation Letter
Appendix H – Consent Form
Appendix I – Thematic Chart Example
Appendix J – System Mapping Workshop – report to participants
Appendix A – List of data requested from MHTSA

Data Requests – Full Data List

The following is a list of the data requested by subject heading.

A. Hearings (asked for in request 1, 29 Jan)

**Purpose**
- Show differences in volume of cases between the different health boards and LAs and any differences in the demographics of cases by area.
- Show the split between hearings that grant a full CTO and those that grant iCTOs – but not the number of CTOs which are granted at the first hearing rather than following an iCTO.

<table>
<thead>
<tr>
<th>1. Number of Compulsory Treatment Order (CTO) Hearings</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local authority</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Multiple Hearings</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of hearings per case</td>
<td></td>
</tr>
<tr>
<td>No. of hearings per patient</td>
<td>Can this show how many different CTO applications have been made for an individual patient?</td>
</tr>
<tr>
<td>Local Authority</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Outcome of CTO Hearings – iCTO, CTO, hospital and community orders</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>All CTO hearings</td>
<td>Include all possible outcomes recorded e.g. hospital order, community order, adjourned, refused, revoked etc</td>
</tr>
<tr>
<td>Local Authority</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
</tbody>
</table>
### B. Applications: Number and Rates by population

**Purpose**
- Show the number of applications in relation to the size of population in local authority areas and any demographic differences.

<table>
<thead>
<tr>
<th><strong>4. CTO Application Numbers and Rates by Population</strong></th>
<th><strong>Notes</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of CTO Applications</td>
<td>Does this show the number of cases or the number of applications?</td>
</tr>
<tr>
<td>- By local authority</td>
<td></td>
</tr>
<tr>
<td>By number of patients</td>
<td>Is it possible to show this so that the number of multiple applications can be deduced?</td>
</tr>
<tr>
<td>Date of Birth</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
</tbody>
</table>

**CTO Application Rates by Population**
- By local authority

<table>
<thead>
<tr>
<th><strong>Date of Birth</strong></th>
<th><strong>Gender</strong></th>
</tr>
</thead>
</table>

### C. Order History

**Purpose**
- Show the individual patient history in relation to CTO orders and the route from an STDC to CTOs.

<table>
<thead>
<tr>
<th><strong>5. Patient CTO Order History</strong></th>
<th><strong>Notes</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>CTO orders granted by Patient</td>
<td>- Will this include all CTO orders the patient has been subject to since October 2005?</td>
</tr>
<tr>
<td>No. of interim CTOs granted by Patient</td>
<td></td>
</tr>
<tr>
<td>No. of Short Term Detention Certificates by Patient</td>
<td>Aware this information is provided by MHOs or taken from CTO application forms and MHTS may not always be notified of an STDC being in place.</td>
</tr>
<tr>
<td>Local Authority</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
</tbody>
</table>
### 6. STDCs Leading to CTOs

<table>
<thead>
<tr>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of STDCs that are followed by a CTO application</td>
</tr>
<tr>
<td>Will this data include lapsed STDCs which are then followed by a CTO application?</td>
</tr>
<tr>
<td>Outcome of CTO applications that follow an STDC</td>
</tr>
<tr>
<td>How will this capture when iCTOs are granted which lead to a CTO?</td>
</tr>
<tr>
<td>Local Authority</td>
</tr>
</tbody>
</table>

### D. Case Type

**Purpose**
- Show the number of hearings which are for CTO applications compared to other orders under the Mental Health (Scotland) Act.

### 7. Proportion of CTOs to other order types

<table>
<thead>
<tr>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of hearings split by application type e.g. CTO, compulsion order</td>
</tr>
<tr>
<td>Number of cases split by application type</td>
</tr>
<tr>
<td>Date of Birth</td>
</tr>
<tr>
<td>Gender</td>
</tr>
</tbody>
</table>

### E. Timescales

**Purpose**
- Show the number of cases that do not hit the legally required timeframes (5 days between two medical exams and fourteen days from 2nd medical exam to submission of application).
- Show when the CTO applications for a patient under an STDC are received.
- Show the time people have to wait for a hearing.
- Show how much advance warning of a hearing is given.
## 8. Meeting Statutory Timescales

<table>
<thead>
<tr>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of cases where the 2 medical exams are not completed within 5 days</td>
</tr>
<tr>
<td>Number of cases where the MHO fails to submit the CTO application within 14 days of the 2nd medical exam</td>
</tr>
</tbody>
</table>

## 9. CTO Application by STDC Timeline

<table>
<thead>
<tr>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>What day on STDC timeline are CTO applications received.</td>
</tr>
</tbody>
</table>

## 10. Timescale from receipt of application to hearing date

<table>
<thead>
<tr>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of days between MHTS receiving CTO application and the date of the 1st hearing.</td>
</tr>
<tr>
<td>No. of days between date of 1st and 2nd hearing.</td>
</tr>
<tr>
<td>No. of days between date of 2nd and 3rd hearing.</td>
</tr>
<tr>
<td><strong>How many hearings do we want to go up to?</strong></td>
</tr>
</tbody>
</table>

## 11. Timescale – Hearing Notice to Hearing Date

<table>
<thead>
<tr>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of days between the issuing of the hearing notice to the date of the hearing</td>
</tr>
</tbody>
</table>

Local Authority

Venue
F. Attendees

**Purpose**
- Show the number of people attending hearings, which category they fall into and whether they gave evidence.

<table>
<thead>
<tr>
<th>12. Type and Number of Hearing Attendees</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average number of people attending a hearing</td>
<td>Is this data only available from October 2007?</td>
</tr>
<tr>
<td>Split between the different types of attendees per hearing</td>
<td>E.g. 100 hearings – 100 RMOs attended, 50 advocates etc.</td>
</tr>
<tr>
<td>Whether the attendees gave evidence</td>
<td>Would this be verbal evidence at the hearing or include written evidence submitted?</td>
</tr>
<tr>
<td>Local Authority</td>
<td></td>
</tr>
</tbody>
</table>

G. Venues

**Purpose**
- The spread of hearings by venue across local authorities.

<table>
<thead>
<tr>
<th>13. No. of hearings by venue</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of hearings by venue</td>
<td></td>
</tr>
<tr>
<td>Outcome of hearings by venue</td>
<td></td>
</tr>
<tr>
<td>Local Authority</td>
<td></td>
</tr>
</tbody>
</table>

H. Mental Illness Classification

**Purpose**
- Shows the different types, and the proportion of patients with different types of mental illness who go through the CTO application and Tribunal process.

<table>
<thead>
<tr>
<th>14. Mental Illness Diagnosis</th>
<th>Notes</th>
</tr>
</thead>
</table>
| Number of different types of mental illness and how many are in each category. | • Our understanding is that this is only coded as mental illness, personality disorder or learning disability (as per the CTO application form)  
• Information from the medical form, including diagnosis is scanned in but not data entered.  
• In order to access this information each individual medical report would need to be reviewed which would require an ethics application. |
I. Reasons for Decisions

Purpose
- Shows the reasons behind decisions made by the Tribunal panel to grant interim orders, to refuse to grant a CTO and why Tribunals are adjourned.

<table>
<thead>
<tr>
<th>15. Reasons for Interim Orders, Refusals and Adjournments</th>
<th>Notes</th>
</tr>
</thead>
</table>
| Range and number of different reasons for granting an interim order | • Our understanding is that this information is written in a free text box which is data entered into the database.  
• A key word search can be carried out on this text, however in order to obtain data which could be reported on the text would need to be coded into reason categories. |
| Range and number of different reasons for refusing a CTO application | Is this reason recorded anywhere by the Tribunal panel members? |
| Range and number of different reasons for an adjournment of a hearing | • Our understanding is that this is a free text box which is part of a document that is scanned in but not keyed into the database. |
| Local Authority | |
| Date of Birth | |
| Gender | |
Appendix B – Stakeholder topic guide case study areas

The Interview aims to explore:

Stakeholder role in the tribunal process, impacts on their work, is it what they expected?
The hearing process - how they are set-up, amount of preparation required, average length of a hearing.
Exploration of how the guiding principles are adhered to or not
Exploration of why there is an increase in the number of iCTOs and multiple hearings
Exploration of the perceived needs of the patient and how they are met or not
Recruitment for system mapping event/ mini focus groups

Introduction/Recap

Background Information
- Recap purpose of study – to explore the early operation of the Mental Health Tribunal for Scotland, part of the Scottish Government’s research programme to evaluate the implementation of the Mental Health Scotland Act
- Explain that the purpose of this interview is to hear their views on the tribunal process and their role within it.

Interview Format
- Format of the interview (open questions, hearing their views)
- No right or wrong answers – their views are important
- Confidentiality and limits around disclosures of harm
- Withdrawal at any time from interview as whole, or in not answering particular questions
- Timing of interview (around one hour)

Recording of Interview
- Digital recording of interviews – check they are happy with this
- Report, use of quotations, anonymisation
- Check if respondent has any questions?
- Check if happy to proceed?

Consent
- Obtain informed consent.
1. Background
The aim here is to understand the stakeholder’s role in the MHTS. The kind of question you could ask to get this section started is – ‘Tell me a bit about your role in the tribunal process?’

Probe on the following:
- Ask them to talk you through a typical case and describe their role – if this is too hard ask them to talk about their most recent hearing.
- How long have they been on the panel/involved in the tribunal?
- Why did they decide to sit on the panel/be involved in the tribunal?
- How many hearings have they been to?
- Were they involved in the sheriff court system of granting compulsory treatment orders before the introduction of the panel?
  - If yes, probe for the main differences with the new system.

2. Hearing process
This section looks at the hearing process in some detail. We want to find out the practical things like how they are set up, what happens if the stakeholder cannot attend and how much time is required for both hearing preparation and attendance? Crucially, we want to know what impact attending a hearing has on other work responsibilities and whether the time commitment is what they expected.

- How is a hearing set up, at what point do they become involved?
- How much notice do they receive of a hearing date?
- What preparation do they do in advance of hearing – how long does this take usually? (For MHOs and RMOs probe on time spent on application form/reports).
- How much of their time does it take on average?
  - probe for time spent at the tribunal, making a decision, preparation – both for single and multiple hearings.
  - Is the time required what they expected?
- What impact does attending a hearing have on their other work?
- Is being involved in the tribunal what they expected. Probe for reasons for answer.
- How often do they attend hearings?
- Have they ever had any problems attending, probe for reasons why if yes.
- What happen if they can’t attend the hearing on the day?
- What changes to the tribunal process would they recommend?

Ask MHOs only
- Are there any practical problems completing the application which may affect the outcome of a hearing, e.g. difficulty getting relevant information?
- How do they submit an application to the tribunal? (i.e. post, email, in person)
  - If delivered by hand how much time does this take? Who delivers it? How much does this cost?
  - How many submit an application by email? Are there any issues with emailing documents – if yes what?

3. Guiding principles
The aim here is to find out how these principles are being used/adhered to in the hearings. There is no time to go through them one by one so you will need to ask how decisions are made in general and then explore how important the guiding principles are.

- What factors are taken into consideration when decisions are made at hearings?
- To what extent are the 10 guiding principles set out in the act used in the decision making process?
  - Probe for any barriers to use of the principles.
- What ones are used most and least, why is this?
- Which ones are most important to you and why?
4. Multiple hearings, iCTOs and Adjournments
The first aim is to explore the reasons behind the high numbers of multiple hearings and iCTOs. The second aim is to find out what kind of impact this has on patients and the stakeholder. Finally, this section explores adjournments.

- Are changes ever made to the programme of treatment recommended in the application for a CTO? If so, what are the reasons for this and does it impact on the process?
- (If not covered already) what are the main reasons for granting an interim CTO?
- (If not covered already) what are the main reasons for multiple hearings?
- What are their thoughts on the number of interim CTOs and multiple hearings – are they higher or lower than they expect? If higher probe on the following:
  o Why this happens?
  o How long this has been happening (i.e. has it started in the last 6 months or has it been like this since the tribunal was introduced).
  o What impact it has on them?
  o What impact it has on the patient and why?
  o Do you think it is a problem?
  o How do you think it can be rectified?

- Have they been to any hearings where there has been an adjournment?
  If yes probe on the following:
  o How often/many times
  o Why do they think there was an adjournment?
  o What the reasons for an adjournment?
  o What impact does this have on you?
  o What impacts do you think this has on the patient and why?

5. Patient needs/experience
This section is about the patient, it looks at how the practical needs of patients to attend a hearing are catered for and, more generally, the impact of the hearing on patient care.

- What special needs might patients have, e.g. interpreters etc?
- In what ways are these needs addressed?
- Does the legal process always work in the patient’s interest?
- In what way does the tribunal focus on legal process rather than quality of care?

6. Closing questions
- How efficient and effective do they think the tribunal process is? Probe for central administration and the local hearing process.
- In what ways can it be improved?

7. System mapping event /mini focus groups
On 24th June we are running a one day system mapping event where we will bring together around 40 people involved in the tribunal process and ask them to share their experience of working. We may wish to invite you to this event. Can we send you some more information on this and an invitation? Who else do you think should be invited, have you got their contact details?
Only ask of stakeholders who are panel members as well
We are planning to hold mini focus group discussions with tribunal panel members after a hearing. Is this something that you can attend?

8. Any other comments/questions?

- Thank respondent for their time
- Reassure re: confidentiality and ask if there is anything they would not like to be discussed/quoted in the final report
- Ask if it is alright to call back check some of the details after the interview
- Check if participant has any questions
Appendix C - Stakeholder topic guide national perspective

The Interview aims to explore:
- Stakeholder role in the tribunal process, views on development and impacts on their work
- The tribunal process – impact on the organisation, its members and other organisations.
- Exploration of how the guiding principles are adhered to or not
- Exploration of why there is an increase in the number of iCTOs and multiple hearings
- Exploration of the perceived needs of the patient and how they are met or not
- Recruitment for system mapping event/ mini focus groups

Introduction/Recap

Background Information
- Recap purpose of study – to explore the early operation of the Mental Health Tribunal for Scotland, part of the Scottish Government’s research programme to evaluate the implementation of the Mental Health Scotland Act
- Explain that the purpose of this interview is to hear their views on the tribunal process and the role of their organisation and members within it.

Interview Format
- Format of the interview (open questions, hearing their views)
- No right or wrong answers – their views are important
- Confidentiality and limits around disclosures of harm
- Withdrawal at any time from interview as whole, or in not answering particular questions
- Timing of interview (around one hour)

Recording of Interview
- Digital recording of interviews – check they are happy with this
- Report, use of quotations, anonymisation
- Check if respondent has any questions?
- Check if happy to proceed?

Consent
- Obtain informed consent.
1. Background
The aim here is to understand the stakeholder’s role and their involvement and knowledge about the development and operation of the MHTS. The kind of question you could ask to get this section started is – ‘Tell me a bit about your role in (insert name of organisation e.g. BMA), ‘What involvement have you had with the new tribunal process?’

Probe on the following:
- What led to the development of the new tribunal process?
- Were they, or their organisation, involved in the decision-making process? What was their involvement?
- Do they have any views on the legislation specifically in relation to the tribunal?
- What are their perceptions of the advantages and disadvantages of the new system?
- Were they involved in the sheriff court system of granting compulsory treatment orders before the introduction of the panel?
  o If yes, probe for the main differences with the new system.

2. Tribunal process
This section looks at the impact that the tribunal process has had on the working of their organisation, their members and other organisations.

Probe on the following:
- What role does the organisation have in the tribunal process e.g. providing information to members, ensuring good standards of care, protecting patients’ rights?
- What impact has the tribunal process had on the organisation, e.g. new staff roles, effect on workload, staff costs?
- BMA, LAW SOCIETY ONLY - What impact has the tribunal process had on their members? What issues are they aware of for their members?
- What impact do they think the tribunal process has on other organisations and individual professional groups – local authorities, health boards, RMOs, psychiatrists, lawyers?
- What are your thoughts on the running of the administration office of the tribunal in Hamilton? (we want to see if they are aware of any staffing issues or management problems)

3. Guiding principles
The aim here is to find out how these principles are being used/adhered to in the tribunal process. There’s no time to go through them one by one so you’ll need to ask in general how important the guiding principles are in the process.
- Do you think the tribunal process takes account of the guiding principles of the MHSA?
- Which principles are most likely not to be adhered to, and why?
- What are the barriers to fulfilling obligations laid out in the guiding principles?
- Which ones are most important in your opinion, and why?

4. Multiple hearings, iCTOs
The aim is to explore their views on the high number of multiple hearings and iCTOs and the impact on who they represent.

- Are they aware that there are a high number of multiple hearings and iCTOs being granted?
- If so, what do they think the cause is of the high number of multiple hearings and iCTOs?
- Probe for thoughts on:
  o How long it’s been happening (i.e. has it started in the last 6 months or has it been like this since the tribunal was introduced).
  o What impact does this have on their organisation and those they represent e.g. doctors, lawyers?
  o What impacts this has on the patient and why?
Do you think this is a problem?
How do you think this can be rectified?

5. Patient needs/experience
This section is about the patient experience of the tribunal process and the impact of the hearing on patient care.
- How well do they think the needs of patients are being met through the tribunal process? Is it achieving what it set out to achieve e.g. appropriate care for the individual?
- Does the process always work in the best interests of the patient? If not, which parts of the process are having negative impacts?
- Does the legal process always work in the patient’s interest?
- In what way does the tribunal focus on legal process rather than quality of care?

6. Closing questions
- How efficient and effective do they think the tribunal process is? Probe for the central administration of it and the local hearing process.
- In what ways can it be improved?

7. System mapping design meeting and workshop/mini focus groups
On 24th June, at COSLA Edinburgh (next to Haymarket Station) we are running a one day system mapping event where we will bring together around 40 people involved in the tribunal process and ask them to share their experience of working. We may wish to invite you to this event. Can we send you some more information on this and an invitation? Who else do you think should be invited, have you got their contact details?

8. Any other comments/questions?
- Thank respondent for their time
- Reassure re: confidentiality and ask if there is anything they would not like to be discussed/quoted in the final report
- Ask if it’s alright to call back check some of the details after the interview
- Check if participant has any questions re. participation
Appendix D – Topic guide for mini focus groups

The key aim of mini group is to explore:

- How decisions in relation to the case that the Tribunal has just heard, were made

And within that context:

- Factors influencing the conduct of the hearing
- Factors influencing the deliberative process
- Perceptions of different Tribunal members about the relative weight of different factors that influenced the decision making process

Introduction

Background Information

- Recap purpose of study – to explore the early operation of the Mental Health Tribunal for Scotland, part of the Scottish Government’s research programme to evaluate the implementation of the Mental Health Scotland Act
- Explain that the purpose of this group discussion is to explore the processes around the decision taken in relation to the case they have just heard. Reassure them that any information they tell us about the case will be kept strictly confidential and patient identity will not be compromised in any way – i.e. we will not publish anything in the report that could identify the patient.

Mini group format

- Format of the group interview (open questions, hearing their views)
- No right or wrong answers – their views are important
- Confidentiality and limits around disclosures of harm
- Withdrawal at any time from group as whole, or in not answering particular questions
- Timing of the mini group (around 45 minutes to one hour)
- Explain that we don’t want to keep them any longer than one hour so your role as facilitator is to keep things moving and you may interrupt if too much time is spent on one subject.

Recording of Interview

- Digital recording of mini group – check they are happy with this
- Report, use of quotations, anonymisation
- Check if there any questions?
- Check if happy to proceed?

Consent

- Obtain informed consent

1. Background

Keep this as brief as possible. Ask each participant to say:

- their name for the tape
- their role on the panel
- the approximate number of hearings they’ve been to

2. Brief description of case

If you’ve not done so already in the introduction set the scene by explaining that the purpose of the discussion is to discuss the case they have just made a decision on. (The idea behind using this approach is to get members to discuss the decision making process whilst it is still fresh in their minds). Hopefully you might have been
allowed to sit in and observe the case and have an understanding of what it was about. Regardless of whether you sat in or not, you’ll need to get an idea of the case and the decision taken. Prompt this by asking something like:

‘Before we start our discussion please give me a brief description of the case you have just heard.’

Make sure you’ve got information on:
- Age and gender of the patient
- The type of order sought
- The decision taken
- The range of people who were at the hearing
- How long it took to reach a decision

3. Hearing process
This section looks at the processes and procedures involved in setting up the hearing they have just been to. We want to find out the practical things like how they were notified about the hearing and how much notice did they receive. How much time is required for both hearing preparation and attendance? The kind of question you need to ask here:
- How were they notified about this hearing?
- How much notice did they receive? Is this level of notice common for other hearings they have attended? Probe for reasons why if not.
- What preparation materials were they given in advance of the hearing and when did they get them – was this similar to other hearings?
- How much of their time did it take to prepare on average? Was this more, less, or the same as usual? If more or less than usual, probe for reasons why.
- How useful was the information they were given? Was any missing? If yes what was it and did this affect their decision? How common is this?
- Probe for more detail about who else attended the hearing (i.e. non panel members) why were they there and what did they contribute?
- Did their attendance influence the hearing, e.g. did they limit or extend what was discussed?

4. The Decision Making Process
The aim here is to explore how the panel made their decision about the case they have just heard.

Start this section of with a general question like:
Talk me through how you made your decision today?

Probe on the following:
- The factors taken into consideration and their reasons for making the decision (e.g. evidence from people attending the hearing, medical reports)
- How long it took to make the decision
- The level of consensus amongst them – how do they resolve differences of opinion? How common it is for there to be differences of opinion amongst the panel? What happened if they cannot make a decision?
- Have they ever had a concern about the decision taken at any of the hearings they have attended? If yes, why and what did they do about it?

5. Numbers of iCTOs
The first aim is explore the reasons behind the high numbers of iCTOs. The second aim is to find out what kind of impact this has on patients.

- If an interim order was granted probe more around the reasons why and how common this is?
- What are the main reasons for granting an interim CTO?
• What are their thoughts on the number of interim CTOs – are they higher or lower than they expect? If higher probe on the following:
  o Why this happens?
  o How long this has been happening (i.e. has it started in the last 6 months or has it been like this since the tribunal was introduced).
  o What impact it has on them?
  o What impact it has on the patient and why?
  o Do they think number of interim orders is a problem?
  o How do they think it can be rectified?

6. Closing questions
• How efficient and effective do they think the tribunal process is? Probe for central administration and the local hearing process.
• In what ways can it be improved?

7. Any other comments/questions?

• Thank respondents for their time
• Reassure re: confidentiality and ask if there is anything they would not like to be discussed/quoted in the final report
• Ask if it's alright to call back check some of the details after the interview
• Check if there are any questions
Appendix E – Research Information Leaflet
An Exploration of the Early Operation of the Mental Health Tribunal for Scotland

This study has been commissioned by the Scottish Government as part of a range of research projects evaluating and providing evidence to support the implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHSA).

The study is being conducted by the Scottish Centre for Social Research (ScotCen) in collaboration with the London School of Economics and Political Science. The findings from the study will inform the ministerial review of the MHSA which focuses on the efficiency and quality of the processes in relation to making civil orders under the Act.

What’s the study about?

This study will focus on exploring the operation of the Tribunal system as laid out in the MHSA 2003. The study will:

- Explore the detailed operation of the Tribunal process, specifically those processes that are perceived to have increased the numbers of interim orders and multiple hearings.
- Assess the views of key stakeholders on these processes, the way in which the Tribunal process operates in practice and the role of participants in the Tribunal hearings process.
- Explore the costs of the Tribunal system, in total and on an individual case and hearing basis.
- Make recommendations for the future development of processes relating to the granting of civil orders in the context of the MHSA.

There are 3 different parts to this study, which you may be asked to participate in:

- Interviews with key stakeholders e.g. Mental Health Officers, psychiatrists, GPs, lawyers, advocates.
- Mini focus groups with the Tribunal panel members following a hearing.
- A System Mapping Workshop to explore and map the practical workings of the Tribunal from the different perspectives of participants in the process (see below for details).

The study will also request the input of those who have knowledge of the costs involved in the operation of the Tribunal system.

System Mapping Workshop
Tuesday 24 June 2008 – COSLA Edinburgh (next to Haymarket station)

A small number of participants (5 - 6) will be brought together in an initial multi-disciplinary design workshop to explore problems they have encountered with the MHTS processes and also what changes they think would make a difference. This will be a half-day in April.

This prepares the way for the System Mapping Workshop by identifying the full range of appropriate participants and by drawing up the ‘archetype’ individual case for the system mapping event that is credible and relevant.

The Workshop will be a full day event, bringing together some 40-50 participants from across the mental health tribunal system. The Workshop will help us to map out the processes as they are now, to understand the system better together, to see how one part of the system affects another part and how the system might potentially be changed.
Your input to the study

We are asking you to take part in the study because you are involved in the Tribunal process and work in one of the 3 case study areas that have been chosen for this study. You may be invited to take part in an interview, a mini group discussion or a design meeting and/or system mapping workshop.

The research will be completed by September 2008 and you can request a copy of the final report.

Do I have to take part?

No. In all our research we rely on voluntary co-operation. The success of the research relies on the goodwill and co-operation of those asked to take part. The more people who do take part, the more useful the results will be. However you do not have to answer any questions you do not wish to and are free to withdraw from any part of the research at any time, without having to give a reason.

Confidentiality

With your permission, the interview or mini focus group will be recorded and transcribed and stored securely with limited access by ScotCen staff. Any information given by respondents will be kept strictly confidential. Verbatim responses will be edited to remove any information which could either directly, or indirectly, identify the respondent. Any direct quotations used in the report will be thoroughly anonymised.

Who is carrying out the study?

The Scottish Centre for Social Research is Scotland’s leading resource for applied research in the area of social policy and public services and was formed in 2004 following the merger of the Scottish Office of the National Centre for Social Research (NatCen) with Scottish Health Feedback, an independent research consultancy. You can find out more at our website: www.scotcen.org.uk.

The LSE group has over 15 years experience of working with public sector practitioners, clinicians, managers and policy makers and the people who use services. They have developed a practical approach to Whole System Working which starts from the assumption that the participants are themselves the resource and the events provide time for them to engage in structured small and large group dialogue.

The Research Team

From ScotCen, the team for the project consists of Claudia Martin (Director), Fiona Dobbie and Anne Birch (Senior Researchers), Susan Reid (Researcher) and Irene Miller (Freelance Researcher).

Pat Gordon, Diane Plamping and Julian Pratt of LSE Health and Social Care will design and conduct the System Mapping Workshop.
Further questions?

If you want further information about the study or to make or change arrangements for an interview please contact:

Lesley Birse, Research Support Manager  or  
Fiona Dobbie, Senior Researcher  
Scottish Centre for Social Research,  
73 Lothian Road, Edinburgh, EH3 9AW  
Tel. 0131 228 2167
### Appendices – Thematic Chart Example

**Appendix F**

#### Chart 2 – Hearings

<table>
<thead>
<tr>
<th>Serial number</th>
<th>Job title</th>
<th>Gender</th>
<th>Type of stakeholder</th>
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<thead>
<tr>
<th>Setting up a hearing/hearing venue</th>
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<tr>
<td>How are hearings set up? How much notice do they receive? What problems does the Hamilton office have setting up the hearings? How are they notified of a hearing? How do they access the paperwork? Where are hearings held, any thoughts on venue and locations. How long does it take to travel and attend a hearing?</td>
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<tr>
<th>Preparation for a hearing</th>
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<td>Anything that talks about the preparation they have to do for a hearing. Is this more or less than expected? What impacts does it have on their other work? NOTE anything to do with preparing the CTO application should go under 2.4.</td>
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<tr>
<th>The actual hearing</th>
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<tr>
<td>Who attends the hearing and why? Who is expected to attend the hearing and why? What happens if they or someone else can’t attend or doesn’t attend? E.g. do they take evidence from them on the phone, send someone in their place? What impact does attending a hearing have on other work? Anything else to do with the actual hearing e.g. having comfort breaks if the patient is there. How long do hearings take?</td>
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As hearing has to be within 5 days of the short term detention order expiring resp has a rough idea of when hearing likely to be. Resp usually lets the tribunal know in advance if application is going to be late on so they can be prepared for it. Also highlights days self & RMO won’t be available to attend. SEE 2.4 (6)

Says not everyone is aware that an awful lot of work goes into organising hearings at the Hamilton end. It’s not easy to find dates & venues. (6)

Thinks venues aren’t always good but in XXX aren’t too bad. There are X good venues. However, the community venues often are booked up which means going up to the hosp despite not being a patient there, which is not ideal. (20)

Has to know application inside out as has to deliver it verbally in the hearing. Have to be on top of the info right up until hearing, taking into account anything new. Will have spent time with patient immediately prior to hearing & with patient’s named person if there is one to explain about tribunal process to try & reassure them. Will have spoken to RMO in days before hearing. Could take a day to do all this. (6,7)

Thinks time whole process involves was what resp expected as more people involved than before & the onus is on MHO to demonstrate why a CTO is needed so that needs time. Says CTO applications & hearings are part & parcel of job as FT MHO but feels it could be more demanding for community colleagues as have other work. Tribunal work has to take priority for resp as is statutory. Does mean they spend less time doing developmental & proactive work & spending time with non detained patients. On a bad week can feel like only doing CTOs & like working for a detention service. (7,8)

Says hearings vary in length but would expect to be rarely less than an hour. Thinks just over an hour is about average but some have lasted 3 or 4 hrs. (7)

RMO, MHO, patient's lawyer, & named person usually invited to attend hearings. Partners of patients sometimes turn up & are usually allowed to stay. Nurses might accompany patients from the ward. Some make it clear are just there as an escort & don't want to be involved, but other times are happy to offer evidence. (8) Patients are not often there but sometimes are. (16)

If a CTO takes place when resp on annual leave has to ask a colleague to pick up the case & attend on resp’s behalf. It's a case of juggling diaries. (9) Would hope to send colleague if couldn't attend at last minute but that has never happened to resp. Says tribunal would be irked if MHO not there as it's the MHO's application. (10,11)
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<th>Serial number</th>
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### Chart 2 – Hearings

#### 2.1 Setting up a hearing/hearing venue

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How are hearings set up? How much notice do they receive? What problems does the Hamilton office have setting up the hearings? How are they notified of a hearing? How do they access the paperwork? Where are hearings held, any thoughts on venue and locations. How long does it take to travel and attend a hearing?

#### 2.2 Preparation for a hearing

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<th>Type of stakeholder</th>
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Anything that talks about the preparation they have to do for a hearing. Is this more or less than expected? What impacts does it have on their other work? NOTE anything to do with preparing the CTO application should go under 2.4.

#### 2.3 The actual hearing

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<th>Job title</th>
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<th>Type of stakeholder</th>
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Who attends the hearing and why? Who is expected to attend the hearing and why? What happens if they or someone else can’t attend or doesn’t attend? E.g. do they take evidence from them on the phone, send someone in their place? What impact does attending a hearing have on other work? Anything else to do with the actual hearing e.g. having comfort breaks if the patient is there. How long do hearings take?

#### 2.4

Be at meetings where people complain, including resp, about the short notice they get but the Act is person-centred and timescale is for the person, so everyone else has to work within that (9, 15). Sometimes gets a week’s notice of a hearing (14). If knows when the 5 day period will be up puts it in diary and phones Hamilton to see if a date has been set (15). Sometimes gets very short notice which is not a problem if has already worked with the patient but is problematic if it is the day before and only gets the chance to meet the patient once before the hearing (15). Once had two hearings booked on one day and went to one with woman had been working with the longest (25).

Prior to tribunal gets info from psychiatrist (1). Sometimes has known the person in the community for a year before hospital, so has good knowledge of their wishes but due to timescales can meet the client on same day as tribunal (2). Need to develop a relationship, build up trust (3). Tells them what their job is and sometimes that is enough for first meeting, especially if distressed, so leaves details and says will be back the next week (3). When goes back talks about the issues, if already on a section often time is running out (3). Tells them about the system, their rights, lawyers, named persons and advanced statements, often do not realise importance of named person (3). Often they ask him to contact a lawyer (3).

Speaks out during hearing if knows that what they are saying the person would disagree with (4). The process is uniform but each hearing is different as it is patient-centred (4Q). Sometimes patients appear at hearing but do not sit through all of hearing, as it can be stressful sitting through all the hearing but still good for the panel to meet the patient in person (10). Told by funders to prioritise tribunals (13). If it is a case where resp does not know client and gets a clash between a meeting and a hearing date can pass it on to a colleague but does not like having to do that (13).

STORY OF WOMAN WITH BIPOLAR DISORDER (SEE 2.2) - the MHO in the hearing reported on what the neighbours had said, hearsay, but the advocate was able to challenge it as he had had time to investigate the background of the woman (16). Some doctors feel it is below them to attend a tribunal, they know best about the patient, it is about ego (20). At some hearings, more early on, the MHO, psychiatrist and lawyers’ egos get involved, showing off their intellect, not good for the patient (21).
Appendix G – System Mapping Workshop Information Leaflet

System Mapping

What happens in each part of the mental health tribunal system has knock-on effects on the effectiveness of the whole tribunal system and other services. These effects are often unexpected and are likely to be known only to some parts of the system. System mapping is a means of enabling participants to share their understanding of the system of which they are a part, recognise its complexity and understand better how it works now and, therefore, how it might be changed.

The workshop is about collective sense-making and complements the individual interviews taking place as part of the research project.

The workshop relies heavily on having a rich mix of participants, usually 30 - 40 people, drawn from both health and legal services and from frontline professionals including clinicians, operational and strategic managers, tribunal members and administrators.

Participants take part in a facilitated exercise. It begins with a story - an archetype, or description of a situation whose essentials will be familiar from experience. Participants describe how this situation might develop, and this is mapped in public on the wall. Participants describe how things really happen rather than how they are supposed to happen.

Provided that there is a richly mixed group of participants, people are almost always surprised by some of the things that go on in a system they thought they knew well. They develop a better understanding of how others see things – the different ‘mental maps’ of other participants – and of the complexity of the knock-on effects that decisions made in one part of the system may have on other parts.

The morning session of the workshop will concentrate on ‘how the mental health tribunal works now’ in relation to compulsory treatment orders. The map of what happens now helps people to see why their system behaves the way it does, and to recognise ‘we’re in this together’. In the afternoon session they go on to explore possibilities for how things might be different and what changes would be necessary to make this happen. Suggestions for improvements ‘surfaced’ during the workshop are discussed. These are summarised and circulated quickly in a report to all participants.
Appendix H – Consent Form

CONSENT FORM

An Exploration of the Early Operation of the Mental Health Tribunal for Scotland

Researchers:
Claudia Martin, Fiona Dobbie, Anne Birch, Susan Reid & Irene Miller
Scottish Centre for Social Research, 73 Lothian Road, Edinburgh EH3 9AW.
0131 228 2167

- I confirm that I have read and understand the information leaflet for the above study and have had the opportunity to ask questions.
- I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason.
- I understand that I may be contacted again by phone or email to ask any follow-up questions to the interview.
- I give permission for the interview/mini focus group to be recorded.
- I understand that I may be contacted again by phone, email or letter to invite me to attend a one-day system mapping workshop in Edinburgh. I understand that participation in this event is voluntary.
- I agree to take part in the above study.

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<th>Name of interviewee (Print name)</th>
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Appendix I – System Mapping Workshop – report to participants

System Mapping Workshop – COSLA June 2008

How can we operate the Mental Health Tribunal System in Scotland effectively for everybody?

Report to participants

Pat Gordon, Diane Plumping and Julian Pratt
www.wholesystems.co.uk
LSE Health and Social Care
14th July 2008
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Background and Purpose

The system mapping workshop was one element of a study commissioned by the Scottish Government as part of a range of research projects designed to support the reform of mental health law in Scotland.

The overall study is being conducted by the Scottish Centre for Social Research (ScotCen) in association with the London School of Economics. The bulk of the research takes the form of interviews with key stakeholders, focus groups with Tribunal Panel Members and an exploration of costs. Some of the participants in the system mapping workshop have also taken part in these aspects of the research.

This research employs the traditional approach in which researchers extract from well-informed insiders their understanding of their world – in this case the operation of the Tribunal system – and distil this into a report that contains qualitative and quantitative data and recommendations. The mental model on which this approach to change is based is one in which it is believed that action (by legislators, by the MHTS and by all the relevant actors in the Tribunal process) is likely to follow from reading such a well-written and well-researched report. Most people experience some level of frustration that this link between research and development is not as strong as they would like it to be.

As part of this study the Scottish Government took the interesting and innovative step of commissioning a second stage of the study in which the focus would shift from gathering and analysing data to addressing mechanisms by which practices, processes and procedures could be improved. They asked for a multidisciplinary approach and for process mapping and a whole system approach to be considered.

A whole system approach employs a mental model which differs from that in which traditional research and development are seen as separate but linked activities. It was developed in the 1990s from a theoretical base in complex adaptive systems and living systems and makes use of practices taken from large group interventions, inquiry methods, dialogue, community development and action research. It differs from traditional research methods in that it brings together local experts in the system in question so that they can learn from each other’s experience. This is not mediated through a report, but takes place through the conversations that take place on the day. It provides an opportunity to ask ‘how are things now?’ and ‘what should we do to improve things?’ (the purposes of research and development) in a single process.

The assumption underlying a whole system approach is that any human system has the capacity to understand itself and to find solutions to its problems, but that it frequently has no access to processes that would enable it to do so.

The role of the group from LSE Health and Social Care – Pat Gordon, Diane Plamping and Julian Pratt – was to design and carry out the system mapping workshop. This is an example of a process that gives the system access to itself so that it can begin to find its own solutions and change its own behaviour (e.g. ‘I will complete the paperwork earlier’). If this sort of process is used at a level where participants already know each other and will continue to work together, our experience is that it can produce lasting systemic change.

We believe that the 2 approaches are complementary. The traditional research methods deliver a documented evidence base while the whole system approach provides an opportunity for people involved in the process to see it from new perspectives, understand the knock-on consequences of their own actions for others, and explore possible improvements together.

An overall report of the whole study of the Tribunal system will be submitted to the Scottish Government in due course. We believe that, as far as this workshop is concerned, it is the conversations that you had on the day, and the new understandings that you took away of how the Tribunal system is seen by others, that is likely to lead to changes in practice. We offer this report to workshop participants as an aide-memoire.

The purpose of the day was to explore mechanisms by which practices, processes and procedures could be improved; and so the main focus of this report is not to describe current problems (which will be documented in the overall report) but to record the possible solutions that were proposed.

**Preparation and overview of the day**

The success of a whole system approach is entirely dependent on ensuring the participation of the ‘right’ people to bring all the relevant perspectives to the joint inquiry. The Scottish Centre for Social Research identified and invited participants from across the 3 case study areas (Highlands, Glasgow and Edinburgh) and from the range of roles involved. The system mapping method limits participation to a maximum of 40-50 and so there were inevitably some gaps, but all 3 areas and all roles participated.

One of the purposes of a workshop like this is to enable the ‘voices least heard’ to contribute. There were a lot of key insights from administrators, for example. And it was a privilege to hear the perspective of a carer – the room quietened whenever she spoke. In spite of the good mix several people said that they wished that others had been present ‘I wish we had brought our local administrator’, ‘We really needed somebody from medical records’.

We began the day by locating the present review of the Tribunal system in the context of the Sheriff Court system that preceded it (session 1) and spent most of the rest of the morning together, mapping the experiences that people have with the Tribunal system (session 2 – system mapping). For the rest of the day small groups explored possible solutions to the question ‘how the Tribunal system might be improved’ (session 3).
Session 1 - the improvements achieved by the new Tribunal system

At the outset we asked participants to think back to the old Sheriff Court system and to think about what was wrong that needed fixing by the new Act.

Participants described some good points about the Sheriff Court system, particularly that it was quick, cheap(er), efficient (though not necessarily effective), did not damage the therapeutic relationship and was easier to understand.

But they agreed that it also had many serious failings, which have been very substantially improved by the Tribunal system; including that it was neither accountable nor transparent, provided no patient voice and inadequate representation, allowed very little dialogue as it was not attended by the patient or RMO, and was stigmatising to patients through its association with the criminal courts.

Session 2 - system mapping – exploring the experiences of people with the Tribunal system

‘Process mapping’ is intended to produce a clear and simple description of the way that a process is ‘meant’ to work. The main output of process mapping is an understandable map that can be shared with others.

‘System mapping’ is another mapping process, which at first sight seems similar but has a different intent. This is to produce a map of the Tribunal system that is not tidied up or simplified in any way, but reflects the complexity of the system as it really is. The output of system mapping is primarily the conversations that occur as the map is produced, and the map itself is usually seen as intriguing rather than informative by people who were not present while it was being produced.

The overall purpose of the system mapping session of the workshop was to enable participants to share their experiences of how the system actually works in practice, as opposed to how it is ‘supposed’ to work. There were several specific aims:

- To enable participants to recognise the complexity of the process, providing a firm foundation for taking stock and continuing to struggle to improve the way that it works.
- To familiarise participants with the parts of the system in which they are not usually involved, which may form the basis for them to adopt different ways of thinking about and acting towards those other parts.
- To identify knock-on consequences of actions in one part of the system for other parts.

In preparation for the system mapping exercise we worked with a small mixed design group (psychiatrist, advocate, MHO, lawyer and representative of MHTS administration, some of whom were also tribunal members) who generously gave half a day to exploring their experiences of the Tribunal system. We were looking for a case study of a patient journey that was familiar and ‘typical’ enough to be recognisable to everybody at the workshop as well as being readily anonymised.

The story needed to be told in ‘instalments’, and from the stories we heard we decided that the ‘decision points’ in the stories were:

- Admission under a short-term detention order.
- 10-12 days after admission.
5 days from the end of the short-term detention order.

Tribunal hearing (leading to an interim order).

Back on the ward.

Second tribunal hearing.

We chose one of the stories and clarified the detail of what actually happened at each of these stages. At the workshop we began by describing the person and the circumstances that had led to their admission under a short-term detention order, and asked you what might happen next. Once you had explored a range of possible occurrences, we were able to say ‘what actually happened at this stage was…. So what might have happened at the next stage?’

As you described the range of actors and the communications between them, we added these to the growing map on the wall and the conversation was thus recorded in an appropriately complex way. Almost everybody contributed to the discussion where this involved the aspects of this journey that they were most familiar with, and remained interested and engaged throughout. The process revealed that there are many variations in working practices, and that there are many perspectives on the way that the Tribunal system actually functions. The purpose of this session was not to try to agree a consensual description but to acknowledge the different perspectives.

The evaluation sheets that you completed at the end of the day will be used to enable us to judge whether to use a whole system approach in this sort of work in the future. The following comments give a flavour of what you felt that you had learned:

- The complex and overlapping roles involved – if it’s confusing for us what’s it like for the client!?
- To see the system mapped out as it is made me realise how complex the system is and how many individuals are involved in getting things through.
- The complexity of the process, the level of co-operation and communication required to operate it, and how the focus on the patient can be lost in the process.
- I learned nothing new.
- I’ve learned a lot about what happens before an application reaches Hamilton.
- The complexity of the system and how unlikely it is that one or two changes will ‘fix’ it.

**Session 3 - how the Tribunal system might be improved**

'It is a great Act formulated with the best intentions from a human rights perspective. Any criticism is aimed at making it better / easier to bear for the person subject to the CTO proceedings'20.

In the final part of the workshop, participants worked in small, mixed groups and were asked to suggest possible ways in which the Tribunal system might be improved. Notes/comments from the facilitators are indented

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20 This quotation is taken from one of the evaluation sheets.
The context of this discussion was a strongly held view that this Act and the Tribunal system is a major improvement on the previous Sheriff Court system; that the system works broadly in the best interests of the patient; and that we should be proud of the Tribunal system and the Act we have in place. We should therefore be prepared to accept the costs in time and money.

On the other hand it was recognised that any improvements in efficiency would free up everybody, particularly clinicians and MHOs, to devote more of their time to patient care; and that it should be possible to carry it out in ways that are less therapeutically damaging.

The aim was to surface a wide range of possibilities, and the suggestions were not necessarily agreed by the small group. Many of the suggestions were raised, and subjected to some discussion, in the whole group; but again we were not looking for agreement and they should therefore be regarded as suggestions with the potential for both intended and unintended consequences, not as recommendations. Some of the suggestions were contradictory. Discussion revealed that at least one suggestion was already in the pipeline, and that may be the case for others.

The suggestions described below are based on notes taken during the plenary session and are as inclusive as possible. They have been supplemented from the flip-charts that the small groups produced where these are clear enough to be self-explanatory. This account is an attempt to summarise a lively discussion.

**In-house screening convenor/Tribunal**

When the CTO form arrives at the MHTS an in-house screening convenor/Tribunal could usefully pursue certain issues immediately in preparation for the Tribunal hearing. This would include identifying errors and omissions, investigating the need for a curator ad litem, legal representation and an independent medical report.

**Dealing with the consequences of the legal / evidential nature of the tribunals**

Many of the dissatisfactions with the Tribunal process reflect the processes that have to be put in place as a result of the requirement that claims be subject to cross-examination. This has particular consequences both for the therapeutic relationship between a person and their clinician and for the efficiency of the process. Nobody challenged the requirement, but there is a clear case for exploring ways in which its negative impacts may be minimised.

Our impression as facilitators was that some of these dissatisfactions may be exacerbated by different usages of the term ‘evidence-based’ to describe an underlying principle of the Tribunal process. Medical practitioners use ‘evidence-based’ to refer to a general truth claim that is asserted and tested in writing (peer-reviewed journals). Legal practitioners used the term to refer to a particular truth claim that is asserted and tested through oral cross-examination. To this group ‘evidence-based’ requires oral hearings – to others it does not.

**Can we avoid damaging repeated oral hearings?**

Oral evidence in the presence of a patient, particularly repeating the reasons for their detention, can be damaging and hurtful to the patient and damaging to the therapeutic relationship, particularly with the RMO. This cannot be in the best interests of the patient.
Participants did not generate any clear possibilities for how this might be improved, but they indicated that there are some questions that might be pursued. Are there any ways of avoiding the repetition? Could the Tribunal make more use of video-links?

**The RMO’s report**
Given the necessity that the RMO be present at a hearing, is a full-length report by an RMO necessary or helpful? Could it be replaced by a brief statement indicating that each of the 5 criteria has been met?

**Written input to Tribunal from named person (and possibly patient)**
Would it be fairer / helpful to allow the named person (and possibly the patient) to submit a written report to be included in the CTO application?

**Reports to Tribunals hearing appeals and variations on an order**
Participants recognised that there are some situations in which papers relating to previous hearings should not be made available because of the risk that they may prejudice the current deliberations. However it was widely felt that, where an appeal is lodged against a CTO, the papers from the original application should be made available to the appeal Tribunal.

The report for that hearing should then describe the case history since the last hearing / decision.

**The duration of orders**
Many patients, admitted on a 28-day short-term detention order, improve rapidly for up to 6 weeks from the onset of admission and introduction of medication. There were suggestions that the number of applications for CTOs could be significantly reduced if the duration of the initial short-term detention order were 42 days.

It was suggested that this increase in the length of the short-term detention order should be accompanied by a new right of the patient or their curator to access a Tribunal hearing within 5 working days at any time on the grounds of changes in material circumstances. This would not be a full hearing, but would address just the material circumstances, and several could be heard in a day.

This is clearly a significant and potentially controversial suggestion. If it is judged to be politically possible to consider it, our suggestion is that it would be helpful to explore the anticipated and unanticipated knock-on consequences in a ‘what if’ scenario exploration with an appropriately mixed group of informants.

**Administration**

**Timing and information**
If CTO applications were submitted by Day 21 of the STDC this would allow the MHTS more time to appoint curators, take greater note of availability when scheduling and provide better notice of hearing date.
Re-design of CTO forms

The problems with the current forms and their undue length and complication are well-rehearsed. Could they be re-designed to be more user-friendly as well as audit-friendly? Separate forms for hospital-based and community-based orders? Would the 5 criteria suffice? Several participants were keen to participate in a review of the forms if one were held.

Our suggestion is that this is an example of where possibilities generated in the workshop should, if taken forward, take place in a way that includes the perspectives of each of the stakeholders.

IT solutions

Participants suggested that IT offers the possibilities of cost savings, time savings and increased confidentiality. Secure transmission of documents requires access to suitable IT systems for both transmission and reception.

It seems that there is work going on to improve the secure transmission, and that a range of perspectives will need to be involved if it is to be accessed in practice in all the relevant NHS and local authority settings.

Access to independent medical report

One suggestion was that all patients should have an independent medical opinion as a matter of course before coming to a Tribunal – that the increase in efficiency and reduction in interim treatment orders would more than compensate for the increased report-writing. Suggestions included that this might be commissioned by the MHTS in all cases, or just in those in which the patient does not commission his/her own, or that one of the two initial medical reports could be an independent medical report.

Another suggestion was that interim orders to allow time for an independent medical report should only be used in cases that are genuinely ambiguous or borderline, though it is not clear whether this could work.

Yet another suggestion was that the medical member of the Tribunal should examine the patient before the hearing and report to the Tribunal (as in England and Wales).

Interested parties to receive a copy of the Tribunal decision

There was a request that those who give evidence, for example the RMO and advocacy worker, should receive a copy of the decision.

Training

Understanding the law

It was clear from some of the discussions that there are instances where a range of actors in the Tribunal process cause delays or confusion because they do not fully understand the law or complete the forms as intended. Participants suggested that there is a need to review the training that is available and its take-up, both for those coming new to the process and as a ‘refresher’.
Initiatives focused on particular roles

Curator ad Litem
The appointment of the Curator ad Litem before the first hearing would reduce the number of interim orders and reduce costs, time and effort. It was recognised that exploring this further would require clarification about the financial responsibility for the appointment.

It would be helpful if somebody were to quality-assure the work of the curator ad litem. It is important that they carry out full duties and attend the hearing.

Named persons
More education is needed about the role of the named person. There was even discussion about whether it would be better to dispense with this role entirely and replace it by that of an advocate, though it was also clear from the discussion that the named person may bring an understanding of the person that nobody else can contribute and which is entirely different from an advocacy role.

MHOs and RMOs
RMOs and MHOs must be able to carry out their full legal duties under the Mental Health Act. For example an MHO needs to be able to see the patient personally before an emergency detention order is made. If this is to happen it requires funding to and by local authorities and health boards.

There is a need for more MHOs, particularly in geographically widespread areas; and political commitment to organise and pay for out-of-hours MHO cover.

We should be actively encouraging more MHOs and RMOs into the mental health system.

Lawyers with an interest in mental health
There is a real deficit, particularly in rural areas, in the number of lawyers skilled and enthusiastic to represent clients at Tribunals. There is a need to train more in this role.

Independent medical specialists
There are clearly times when delays in getting an independent medial report lead to the granting of an interim order. One suggestion, that the Royal College produce a list of committed providers (particularly in sub-specialist areas), was discovered to be in hand and will be completed within the next two weeks. This was widely welcomed.

Tribunal Panel Members
There was quite a widespread feeling that the general member of the Tribunal was too often somebody who works or has worked in the mental health field, for example as a CPN, introducing a bias towards ‘insiders’. It was suggested that more effort should be made to recruit more members of the public, service users and carers.

It was suggested that the training of Tribunal members should include more about understanding the experience of patients, about how to engage them and not to exclude them.
There is a particular issue about Sheriffs on Tribunals as they bring a different style of working and culture from their own courts and are used to court clerks who do much more than the MHTS secretariat.

It was suggested that more thought should be given to the appointment of convenors in order to bring in new blood, including a review of their term of office and financial rewards.

**The need for a spokesperson to address the media**

There is a need for a government spokesperson to speak on behalf of the MHTS, to convey the success that it has in balancing different needs and priorities.

**Prevention – increasing rates of non-compulsory care**

Are there ways in which voluntary admission could be made more likely, such as nicer hospitals and more comprehensive community services that allow community orders?

**Reflections - what I might do differently**

The Scottish Government commissioned this research to inform the ministerial review of the Mental Health (Scotland) Act. They included a whole system component in the study, recognising that the way that a complex human system behaves is co-ordinated both by national policy frameworks and by the relationships and behaviours of all those involved at the level of implementation.

Many of the suggestions in the previous section were for things for others to do – for the whole system to do or even for the legislature to do. But the discussions also led to new insights by individual participants and to things that they felt that they could go away and do differently as agents in the system. A few comments that stand out are:

- Encourage earlier submission of applications
- I will now focus more on welcoming the patient and involving them when sitting on Tribunals
- Make more effort with named persons.
- Communicate better throughout the process / link in better with advocacy / lodge my application electronically.
- Provide paperwork earlier / talk to patients about Tribunal.
- If I know a CTO will be applied for, to ask the RMO earlier for the medical and get the application in within the 28 days.
- Communicate directly by phone with MHT admin staff.

**Conclusion**

The participants were strongly in favour of the principles of the Act and keen for it to work in the most efficient way possible compatible with acting in the best interests of the patient.

They had plenty of suggestions about how things might be improved. Our recommendation is that these possibilities be explored further by small groups bringing the wide range of perspectives that proved to be so fruitful in the workshop.
## Participant list

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<thead>
<tr>
<th>Name</th>
<th>Surname</th>
<th>Role</th>
<th>Organisation</th>
<th>Case Area</th>
<th>Study Area</th>
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<tr>
<td>Karen</td>
<td>Alexander</td>
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<tr>
<td>Sue</td>
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<tr>
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<td>Lorna</td>
<td>Brown</td>
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<td>Alex</td>
<td>Campbell</td>
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<td>Moira Paterson</td>
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<td>George W Paterson</td>
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