THE MENTAL HEALTH REVIEW TRIBUNAL - March 2006

1. Principles

1.1 In the course of review of the Mental Health Review Tribunal ("the Tribunal") our deliberations have been in accordance with the principles identified in the terms of reference for the statutory review and the principles upon which the other sub groups have operated when considering Definitions, Guardianship and the Mental Health Commission, which include in particular:-

- non-discrimination – those with mental disorder should retain the same rights as those with other health needs whenever possible;

- equality – the Tribunal powers should be exercised without any discrimination on the grounds of disability, age, gender, sexual orientation, language, religion, or national, ethnic or social origin;

- respect for diversity – those who come before the Tribunal should receive a hearing and the decision in a manner that records respect for their human rights and individuality and properly takes into account age, gender, sexual orientation, ethnic group and social culture and religious backgrounds;

- reciprocity - where the Tribunal imposes an obligation on an individual to remain subject to medical treatment for mental disorder in the hospital or in community environment, a corresponding obligation on the Health and Social Care Authorities should exist to provide safe and appropriate services and ongoing care including, were applicable, in the community;

- participation – the wishes of those who appear before the Tribunal should be ascertained and taken into account and should be provided with information which is not detrimental to their health and safety or to the health and safety of others, and they should be provided with such support as is necessary to enable their participation in the proceedings;

- respect for carers – respect should be afforded to the role and experience of those who care for patients, who should receive appropriate information, advice and consideration of their views and needs;

- least restrictive alternative and informality – the Tribunal should strive to ensure that a patient's mental health needs are provided in the least restrictive manner and environment, but always compatible with provision of safe and effective care for the patients and others, and whenever possible detention for medical treatment should not be the course of first choice, but imposed only where necessary to protect the patient and/or others from serious physical harm;

- respect for rights - compliance with the rights and responsibilities enacted by the provisions of the Human Rights Act 1998 should be ensured in the conduct of proceedings and the provision of reasoned decisions.

1.2 The recommendations are evidence based, presented on the basis of change of the current system in response to identified and perceived weaknesses, and attempting to build on the strengths of the current system including those which Health Boards/multi-disciplinary groups tend not to utilise.

2. Regional Consultations

2.1 Submissions that were considered were also received from:

- Eastern Health and Social Services Board
- Southern Health and Social Services Board
- Down Lisburn Trust
- North and West Belfast Trust
- British Medical Association, Northern Ireland
- Newry and Mourne Approved Social Worker Forum
- NI Dementia Forum
- Belfast Traveller's Support Group
- LAMP
- Cause for Mental Health
- Northern Ireland Office, Criminal Justice Division
- Mental Health Users Reference Group
- The Patients' Advocate
- The Northern Ireland Human Rights Commission.

2.2 No submissions were received that suggested there should not be a Tribunal.

3. Summary of Current Jurisdiction and Powers

(In the text the numbers enclosed in brackets "[ ]", refer to relevant Articles in the 1986 Order).

3.1 The jurisdiction and operation of the Tribunal are set out in the Mental Health Order (Northern Ireland) 1986, and in regulations that govern the procedure. The principal regulations are the Mental Health Review Tribunal (Northern Ireland) Rules 1986 to which there have been some amendments, the most recent being the Mental Health (Amendment) (Northern Ireland) Order 2004. The powers of the Tribunal are quite specific and are governed by the Order and Regulations. The Tribunal has no powers or functions outside those granted in the legislation. The Tribunal is a Court.

3.2 The entire Tribunal consists of a panel of 8 legal members (two of whom have been appointed as Chair and Deputy Chair respectively) 8 medical members (who are Consultant Psychiatrists) and 8 lay members all of whom have been appointed by the Lord Chancellor. The Tribunal when sitting for the purpose of proceedings under the 1986 Order consists of a legal member who is the President, a medical member, and a lay member. Three only of the Presidents are specifically appointed by the Lord Chancellor to preside at Tribunals concerning restricted patients – those subject to a Hospital Order imposed by a court of criminal jurisdiction.

3.3 A patient is a person who suffers from or who appears to suffer from a mental disorder, and is either a detained patient, or a patient subject to guardianship, or a restricted patient (one who is subject to a hospital order with restrictions by virtue of which discharge from hospital is restricted).

3.4 The Trust having the responsibility for a detained patient or a patient who is subject to guardianship is under a statutory duty to inform the patient (amongst other matters) under which statutory provisions they are being detained or subject to guardianship and of their rights of applying to the Tribunal [27(1)].

3.5 A patient's case falls to be considered by the Tribunal as a result of one or more of the following events:

1. The patient's application for discharge from detained status. There are various statutory periods within which a patient may apply, subject to the patient's status – detained; subject to guardianship; restricted under a Hospital Order, conditionally discharged: [71(1), 71(3), 75, 80(2)].
2. The application of the patient's nearest relative, as defined: [32(1)], in certain circumstances: [71(4)].
3. A reference by the Health Board/Trust (referred to as the "Authority") if the patient's status has not been considered by the Tribunal within the previous two years: [73].
4. A reference by the Secretary of State in respect of a restricted patient at any time, and in any event if the patient's status has not been considered by the Tribunal within the previous two years: [76], and if a conditionally discharged restricted patient is subsequently recalled to hospital, within one month of the day on which such patient returns: [80(1)].
5. A reference by the Attorney General, DHSS or, on the direction of the High Court, the Master (Care and Protection), at any time [72(1)].
6. A reference by the Mental Health Commission: [86(3)].

3.6 Prior to the hearing the Tribunal members will have been supplied with written reports from the patient's Responsible Medical Officer ("the RMO") and from the patient's Social Worker for consideration together with oral evidence at a hearing. The reports or part thereof may be withheld from the patient on the ground, to be stated as a preamble to the report in question, *"that its disclosure would adversely affect the health or welfare of the patient or others"*. The same provision applies in relation to withholding disclosure of documents other than the Authority's reports. In relation to reports, the part to be withheld *"shall be made in a separate document in which shall be set out the reasons for believing that its disclosure would have that effect"*.

3.7 The RMO's report should contain information to enable the Tribunal to ascertain the following, always subject to the oral evidence to be adduced at the hearing:

1. The RMO's diagnosis of the "mental disorder" then suffered by the patient.
   The relevance of this is that unless the patient (other than a patient who is subject to guardianship) suffers from a "mental illness" as defined: *"a state of mind which affects a person's thinking, perceiving, emotion or judgment to the extent that he requires care or medical treatment in his own interests or the interests of*

other persons" [3(1)], or suffers from "severe mental impairment" as defined: *" a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned"* [3(1)], the Tribunal must discharge the patient: [77(1)]. The Tribunal has no jurisdiction in respect of other forms of mental disorder.

2. Whether the nature or degree of the mental illness or severe mental impairment suffered is such that it warrants the patient's detention in hospital for medical treatment. If the nature or degree of either of these forms of mental disorder are not such as to warrant detention in hospital for treatment, the Tribunal must discharge the patient: [77(1)(a)].

3. Whether discharge would created a substantial likelihood of serious physical harm to the patient and/or to other persons: [77(1)(b)].
   If there is not a substantial likelihood of serious physical harm the Tribunal must order discharge: [77(1)(b)].

3.8 There are statutory provisions that must be considered in determining whether the discharge of a patient would create a substantial likelihood of serious physical harm: [2(4)].

- The Tribunal must consider whether there is a substantial likelihood of serious physical harm to that patient: [2(4)(a)]
  The Order provides that "*regard shall be had only to evidence that the patient has inflicted, or threatened or attempted to inflict, serious physical harm on himself; or that the patient's judgment is so affected that he is, or would soon be, unable to protect himself against serious physical harm and that reasonable provision for his protection is not available in the community"*. [2(4)(a)(i) & (ii)].
- The Tribunal must consider whether there is a substantial likelihood of serious physical harm to other persons: [2(4)(b)].
  The Order provides that "*regard shall be had only to evidence that the patient has behaved violently towards other persons or that the patient has so behaved himself that other persons were placed in reasonable fear of serious physical harm to themselves"*: [2(4)(b)(i) & (ii)].
  If there is no evidence that discharge would create the likelihood of serious physical harm to the patient or to other persons, the patient's detention is unjustified, and the Tribunal is obliged to order discharge – even if detention in hospital for treatment of the patient's mental illness or severe mental impairment is considered by all concerned to be in the patient's best interests.
- In the case of an application by the nearest relative, the Tribunal must consider whether the patient would receive proper care if discharged: [77(1)(c)].

3.9 A Social Worker usually prepares the up-to-date social circumstances report to the Tribunal on specified matters to be considered before a decision is reached on whether the patient should be discharged following the application of the foregoing statutory criteria. The matters to be considered are the patient's home and family circumstances, including the attitude of the patient's nearest relative or the person so acting; the opportunities for employment or occupation and the housing facilities

which would be available to the patient if discharged; the availability of community support and relevant medical facilities; the financial circumstances of the patient.

3.10 In the case of a restricted patient exactly the same considerations apply in relation to the evidence to be presented concerning a detained patient, but with the added provision that conditional discharge orders are possible. The effect of the provisions [78 (1) & (2)] is that if the evidence does not at the time of the hearing satisfy the Tribunal that the restricted patient suffers from mental illness or severe mental impairment of a nature or degree to warrant detention in hospital for treatment, or does not satisfy the Tribunal that discharge would cause serious physical harm to the patient or to others, the Tribunal must additionally consider whether it is nevertheless appropriate for the patient after discharge to remain liable to be recalled into hospital for treatment. If so, a conditional discharge can be ordered.

The terms of the Order can require the patient to comply with such conditions as the Tribunal imposes at the time of making the order. The Secretary of State can also impose or vary conditions for compliance at any time thereafter, and can recall the conditionally discharged restricted patient at any time: [78(4)].

The Tribunal is not empowered to make a conditional discharge order in respect of any patient who is not subject to a restriction order.

3.11 When the patient is subject to guardianship the criteria, and therefore the evidence which is required to enable the Tribunal to reach a decision as to whether guardianship of the patient should continue, is somewhat different: [77(3)]. The requirement is that the Tribunal must order that the patient be discharged if not suffering from mental illness or severe mental handicap of a nature or degree to warrant remaining under guardianship; or if it is not necessary in the interests of the welfare of the patient to remain under guardianship [77(3)(a) & (b)].

Severe mental handicap is different from severe mental impairment and is defined as *"a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning"* [3(1)]. There is no requirement in a guardianship case to consider evidence of severe mental impairment or of the likelihood of harm if discharged. Such evidence, if it exists, could be relevant to justify the constraints of guardianship to control behaviour in the interests of the patient's welfare, but the criterion is whether it is *"necessary in the interests of the welfare of the patient that he should remain under guardianship*". If it is not necessary, the Tribunal must order discharge.

3.12 The secretariat of the Tribunal will arrange the date and the place of hearing, usually the hospital in which the patient is treated, or in guardianship cases often at a Health Centre.

3.13 Procedure at the hearing is regulated by Article 83 of the Order and by the 1986 Rules.

- The Tribunal will have a typed copy of the notes of a previous decision, if any.
- The Psychiatrist member will interview the patient and perhaps members of staff, and consider the medical records beforehand. It is not imperative that the Tribunal must interview the patient, unless the patient so requests. The Tribunal

must interview the patient in the absence of any other person if so requested by the patient: (Rule 22(2)).

- The Tribunal may conduct the hearing in such manner as it considers most suitable bearing in mind the health and interests of the patient: (Rule 22(1)).
- The Tribunal sits with a member of the secretariat who notes the proceedings.
- When the Tribunal sits, the Psychiatrist orally reports the interview with the patient and staff and the review of the notes, before any others persons are present. If relevant information is included in the psychiatrist member's report to the Tribunal of the interview with the patient, this information is disclosed to the participants at the hearing who have the opportunity to respond.
- The President introduces the participants and the Tribunal members, and explains the manner of proceeding which it is proposed to adopt: (Rule 22(3)).
- The patient can be, and often is, represented by Counsel or Solicitor. If so, in practice the Authority will have legal representation by Solicitor or Counsel. The rules empower the Tribunal to appoint a person to act for a patient who does not want to conduct their own case or to appoint a representative.
- The patient is entitled to be present throughout, but the issue as to whether the patient should be excluded from the hearing or any part thereof often arises. The Tribunal will make the decision after considering the views expressed by the patient or through the representative, if any, and by the RMO through the Authority's representative, if any, and by the Psychiatrist member. Exclusion of patients against their will is only on the basis that it would be contrary to the best interests of the health or welfare of the patient or others to hear all the evidence. The Tribunal can exclude other persons from the hearing, and is required to inform the patient, or an applicant or their representative or the Authority's representative who is to be excluded, of the reasons for the exclusion, and to record those reasons in writing: (Rules 6 and 21(4)).
- The patient can seek a private interview with the Tribunal members in the absence of any other person.
- The Tribunal sits in private unless the patient requests otherwise and the Tribunal is satisfied admission of members of the public (which includes relatives and friends of the patient) would not be contrary to the interests of the patient: (Rule 21(1)). The patient must be informed of the reasons for a refusal of the patient's request and the Tribunal must record the reasons in writing: (Rule 21(2)). Even when the Tribunal sits in private it may admit such persons on such terms and conditions, as it considers appropriate: (Rule 21(3)).
- The Tribunal has always interpreted the legislation as imposing the burden upon the Authority to justify that the detention or guardianship of the patient is within the statutory criteria. The patient is prima facie entitled to liberty. (This interpretation has been accepted as correct in a recent High Court judgment. The statutory requirement concerning the burden of proof on the Authority has been clarified in the 2004 Amendment Order).
- The Tribunal must seek to avoid formality in the proceedings as far as is appropriate: (Rule 22(1). Structure is appropriate, and the President should explain the manner of proceeding that the Tribunal proposes to adopt: (Rule 22(3)).
- The RMO and Social Worker will give evidence additional to or in support of the evidence in their reports, and then will be subject to cross-questioning on behalf of the patient.

- Strict rules of evidence do not apply: (Rule 14(2).
- The patient is then given the opportunity to give and call evidence. The patient should always be given the opportunity to speak: (Rule 22(4)).
- Any additional evidence can follow from other sources: (Rule 22(4)).
- After all evidence is given, the applicant, and where the patient is not the applicant, the patient, must be given the further opportunity to address the Tribunal: (Rule 22(5)).
- Throughout the proceedings attempts should be made to reduce the stress experienced by the patient. The RMO will be present throughout, unless the patient has requested an interview in the absence of any other person, including the RMO: (Rule 22(2)).

3.14 The decision of the Tribunal must be in accordance with the evidence. The options are:

1. In every case there is the discretion to discharge even where the statutory criteria for detention or continuance in guardianship have been satisfied: [77(1)].
2. To order detention to continue when all relevant criteria have been satisfied. This order may be accompanied with a recommendation to grant leave of absence or to transfer to another hospital or into guardianship with a view to facilitate discharge at a future date: [77(2)(a)]. If such recommendation is not complied with, the Tribunal can further reconsider the case: [77(2)(b)].
3. To order discharge when one or more of the criteria have not been satisfied. Discharge may be delayed to a specified date e.g. to facilitate setting up alternative accommodation or supervisory facilities: [77(2)].
4. In the case of a restricted patient, to order a conditional discharge: [78(2)].
5. In the case of guardianship, to order discharge from guardianship, or to continue with guardianship: [77(3)].
6. In any case to adjourn the hearing for the purpose of obtaining further information or for other appropriate purposes: (Rule 16).

3.15 The President may announce the decision immediately after the hearing of the case, but in any event within 14 days of the hearing the decision must be recorded in writing with reasons that address the statutory criteria, signed by the President, and communicated to all the parties: (Rule 24(1)). Sometimes the reasons will be withheld from the patient and/or others (such as relatives): (Rule 24(2)).

3.16 There is no automatic right to an appeal from the Tribunal's decision. The Tribunal may state a special case for determination by the Court of Appeal of any question of law which may arise before it, and must state a case if so required by the Court of Appeal: [83(7)]. The decisions of the Tribunal are liable to be subject to Judicial Review by the High Court. Otherwise, a right of appeal from a decision of the Tribunal does not exist.

4. Background Information

4.1 There are 8 members of the legal professions appointed as presidents, to preside at individual Tribunals. Of the 8, two are additionally chairman, and deputy chairman respectively of the Tribunal. Of the 8 the chairman and deputy chairman and one other president only are enabled by appointment of the Lord Chancellor to preside at a Tribunal concerning a restricted patient.

4.2 There are 8 medical members of the Tribunal, all of whom are consultant psychiatrists, and their numbers amount to just over 7% of all consultant psychiatrists in Northern Ireland.

4.3 There are 8 lay members of the Tribunal. Lay members have a public service/administration/social work background.

4.4 In the year ended 31 March 2003 applications and references totalled 239.
In year ended 31 March 2002 applications and references totalled 189.
In year ended 31 March 2001 applications and references totalled 223.

4.5 Outcome following applications and references:

4.5.1 Year ended 31 March 2003:

- Of the 239 applications and references relating to detained patients and patients subject to guardianship plus 20 carried forward from the previous year, 112 patients, 44%, were re-graded before the hearing, and 13 were re-graded by decision of Tribunal. Consequently 48% of patients did not remain in the detained or guardianship status between the time the application or reference was made to the Tribunal and the date of decision of the Tribunal.
- Of the patients in respect of whom applications/references proceeded to a hearing, 85% had legal representation.
- Of the cases heard 100, 76%, confirmatory orders were made.

4.5.2 Year ended 31 March 2002:

- Of the 189 applications and references relating to detained patients and patients subject to guardianship plus 16 carried forward from the previous year, 96 patients, 47%, were re-graded before the hearing, and 12 were re-graded by decision of Tribunal. Consequently 53% of patients did not remain in the detained or guardianship status between the time the application or reference was made to the Tribunal and the date of decision of the Tribunal.
- Of the patients in respect of whom applications/references proceeded to a hearing, 93% had legal representation.
- Of the cases heard 78, 74%, confirmatory orders were made.

4.5.3 Year ended 31 March 2001:

- Of the 223 applications and references relating to detained patients and patients subject to guardianship plus 19 carried forward from the previous year, 103 patients, 42.5%, were re-graded before the hearing, and 13 were re-graded by decision of Tribunal. Consequently 44% of patients did not remain in the detained or guardianship status between the time the application or reference was made to the Tribunal and the date of decision of the Tribunal.

- Of the patients in respect of whom applications/references proceeded to a hearing, 83% had legal representation.
- Of the cases heard 97, 75%, confirmatory orders were made.

4.6 Three members of secretariat staff provide existing administrative support, and every Tribunal is attended by one member of staff.

4.7 Tribunal hearings in relation to detained patients are located in the hospital where the patient is detained, most often in a boardroom or conference room. In relation to restricted conditionally discharged patients or patients subject to guardianship, hearings are frequently held in a health centre if not in a hospital convenient to the location of the patient in the community. Generally facilities are adequate for the hearing, comprising a large table or number of tables together with chairs around the perimeter. The general atmosphere of hearings is informal but with structure, and the environment contributes to an atmosphere of informality. Participants are together around the table and this format allows a degree of informality, which is desirable. Structure is achieved by the Tribunal hearing oral evidence to supplement the documentary evidence from the RMO which is subject to cross-questioning on behalf of the patient and by the Tribunal, followed by the same procedure in relation to the social worker and other participants upon whom the Authority relies. This is followed by the patient having the opportunity to give evidence, subject to cross-questioning on behalf of the Authority and by the Tribunal. The authority is invariably represented by solicitor or counsel when the patient has legal representation. Closing submissions are invited and the decision follows private discussion between members of the Tribunal. The decision must be reduced to writing with reasons and transmitted to the patient and the Authority within 14 days.

5. The Northern Ireland Human Rights Commission Report December 2003 Chapter 3 concerning the Mental Health Review Tribunal

The report at Chapter 3 concerning the Tribunal and the recommendations therein received further careful consideration. Deliberations from the outset had, before publication of the Report, been conducted with a view to ensuring compliance with the provisions of the Human Rights Act 1998. More detailed responses to the recommendations in the NIHR Commission Report concerning the Tribunal are set out in section 8 below.

6. Evidence from Users and Carers Groups

The review of the Tribunal has recognised the primacy of the views expressed by the users and carers who have made submissions and who have been consulted. They have been recognised as the most important group for whose benefit the entire Review and in particular the review of the Tribunal's functions and powers is designed to facilitate in accordance with the principles set out at paragraph 1. The sub group has paid close attention to the views expressed in the course of meetings with carers and users groups some of whose views have been subjected to robust discussion and some rejection within the sub-group. The responses to the submissions of the Users Reference Group are included in section 7 below. The Users Reference Group members supported the existence of the Mental Health Review Tribunal system and did not express any criticism of the method or procedure of hearings. Submissions did not include any comments regarding perceived delay included in some other contributors' submissions – there was no dissatisfaction reported regarding lapse of time between dates of application and hearing. Their submissions related to circumstances, which exist before a Tribunal is engaged, as follows:

- often the patient is transferred to voluntary status just before the Tribunal hearing, which leads to lack of accountability for the period of detention;
- the Tribunal system should apply to voluntary patients as well as those detained;
- there should be access to an advocate who can take the time to make patients aware of their rights in a way which they can take in and understand and who can take action when the patient is not well enough to do so, because patients were not consistently made aware of their right of application to a Tribunal – notwithstanding the statutory duties referred to in paragraph 3.4.
- hearings should be outside the hospital setting;
- patients are unwilling to ask for Tribunal hearings as they can then be labelled as a troublemaker and there can be reprisals including confinement to bed, removal of clothing, and medication.

7. Major Recommendations

The recommendations are evidence based, presented on the basis of change of the current system in response to submissions received and to identified and perceived weaknesses, and attempt to build on the strengths of the current system including those which Authority's multi-disciplinary teams have tended not to utilise.

7.1 There should be an independent Mental Health Review Tribunal the powers and duties of which must be in compliance with Human Rights legislation. The powers and duties must be coterminous and cannot be more extensive than those in relation to the powers and duties of the Authority to admit a patient for assessment, or to detain, or to admit into guardianship.

7.2 The Tribunal which is convened for the purpose of hearing a particular application or reference should be comprised of three members: a legally qualified member to preside, a medical member who should be specified as a consultant psychiatrist, and another member who is neither. Although there have been concerns expressed about the desirability of having a psychiatrist examine and interview the patient and staff and report to the Tribunal and also sit as a member of the Tribunal in the decision making process, the persons who appear before the Tribunal on review should be entitled to have their medical condition assessed independently. Ideally this may be by a consultant psychiatrist with qualifications and experience appropriate to the mental disorder of which the patient involved suffers, but availability of consultant psychiatrists as members of the Tribunal will often preclude the specialism of the psychiatrist matching the patient, or would cause delay of the hearing for an unacceptable period. In any event the fact that the psychiatrist member may not be a specialist in the area of psychiatry applicable to the patient could have a beneficial result in reducing the perceived impact of the psychiatrist's opinion both as examiner and contributor to the decision. As any tribunal should be comprised of at least 3 members, a lay member rather than another legal or medical member is appropriate.

7.3 The psychiatrist member should be empowered to examine and interview the patient and medical records and to interview nursing staff, prior to the hearing.

7.4 The psychiatrist member should convey to the members of the Tribunal his conclusions on the patient's mental state as a result of his interview. The psychiatrist member should refer to such evidence as appears from the medical records and

interview as is relevant to the Tribunal's assessment of the patient's propensity to cause or suffer serious physical harm to self or others. Concerns have been expressed that this information may be additional to information adduced in documentary and oral evidence at the hearing, and that it may not effectively or at all be disclosed to the patient and the Authority. These concerns may be addressed by two alternative courses. Either, if the report does not accord with the evidence of or on behalf of the Authority or patient or includes relevant matters not disclosed in their evidence, the discord should be disclosed in the course of the hearing. Or the report of the examination and interview by the psychiatrist should be disclosed orally in the presence of the Authority and patient's respective representatives and witnesses before any other oral evidence is given. The latter course is recommended.

It would be better to include the provision of choice in a Code of Practice than in legislation.

7.5 The frequency with which applications/references may be made to theTribunal:

7.5.1 The current periods permit the nearest relative to refer once within 28 days of being informed that he/she has been barred from ordering the patient's discharge, and once in the first 12-month period of detention or acceptance into guardianship and every 12 months thereafter. The 12-month periods should be reduced to 6 months and should apply to the person who may replace the "nearest relative" in new legislation. The 28-day period may be too rigid in the potential emotional circumstances and the need to seek advice regarding an application, and should be extended to 8 weeks.

7.5.2 Patients should be able to apply during the period of admission for assessment and once during the first 6 months of detention or guardianship beginning with the date of admission for assessment or acceptance of guardianship application, and once during the 6 month period beginning with the date of the first renewal of the authority and once in each subsequent period of 6 months.

7.5.3 The discretionary referral at any time by the Attorney General, the Department of Health and Social Services, the Master (Care and Protection), and by the Mental Health Commission should be continued.

7.5.4 The patient should be referred for review by the Authority automatically if the patient's case has not been considered by a Tribunal within the period of 12 months, but within 6 months if the patient is under 16 years of age within any portion of such 6 month period, following the date of the previous renewal of authority for detention or guardianship. There should not be an additional automatic review to the Tribunal.

7.5.5 Both unrestricted and restricted offender patients should have the same entitlement regarding timing of applications and references as non-offender patients, with the date of the hospital order or transfer to hospital direction treated as the date of admission.

7.5.6 Conditionally discharged offender patients should be able to apply once in the first 12-month period following conditional discharge and annually thereafter if not recalled to hospital. If recalled the Secretary of State should refer to the Tribunal within 28 days of return.

7.5.7 A Code of Practice should include a provision that all detained patients and those subject to guardianship must be informed by the RMO or Approved

Social Worker or other member of the applicable multi-disciplinary team within 24 hours of the commencement of every period of authority for assessment or of detention for treatment or renewal thereof or admission to guardianship, of the right to apply for review of the authority by the Tribunal, with a note to the same effect entered in the patient's medical records.

7.5.8 Authority for detention should automatically lapse if and when a detained patient has absconded and remains at large for 28 or more days, as currently.

7.6 The Tribunal should continue to have the ability to consider a reference for review by consideration of reports and records alone, without causing the disturbance to a patient, which can result from a hearing. This power exists in current rules, but is rarely if ever utilised. There is evidence the automatic referral and full hearing does disturb many chronically ill patients who have no desire to be discharged, and feel threatened that discharge may result from a referral hearing. However, if the decision as a result of a review of the papers is likely to be to direct discharge, a full hearing with the representation of the patient and of the Authority should be mandatory before a final decision is reached.

7.7 The current test of whether the Authority is entitled to withhold reports and other documents from the patient, should be changed to "*Full disclosure of documentation should be made except in special cases where it is determined that a specific disclosure to the patient would cause serious harm to the patient's health or put at risk the safety of others*".

7.8 The current Article 10 protection from disclosure by a person of admission for assessment, which is not immediately followed by detention for treatment, is insufficient as it is liable to be considered discriminatory. When a person is admitted for assessment and detained for the assessment period, but does not become liable to detention for treatment at the end of the assessment period of up to 14 days, this admission does not require to be disclosed and cannot be relied upon by others for certain purposes. The protection is lost even if the patient is subsequently discharged from detention for treatment by the Authority at any time, however short, after the 14-day period. The protection should be extended to include patients who have been discharged by the Authority from detention for treatment or who have applied or been referred to the Tribunal during the period of assessment and/or during the first 6 months of detention or guardianship beginning with the date of admission for assessment or acceptance of guardianship application, and who have then been discharged by direction of the Tribunal.

7.9 The Tribunal should continue to have the ability to appoint a person to safeguard a patient's right to be represented at the hearing. This right is of particular importance where the patient is perceived by the Social Worker and/or Responsible Medical Officer not to have the capacity to decide whether or not to seek representation.

It could be appropriate for a Code of Practice to include advice that when the power to appoint legal representation is exercised by the Tribunal in respect of a child, that a Solicitor accredited by the Law Society for that purpose should be appointed.

7.10 Every patient should be entitled to legal aid for representation at every hearing, because patients are either detained against their will (otherwise no reason for the

application) or their cases are referred for review (a review the patient had not sought). The treatment provided is funded by the state under the National Health Service, and the exercise of statutory rights of applications or of references should not require any patient to pay for representation from their own funds, but should be funded by the state under the Legal Aid scheme or its equivalent.

7.11 There should be a right of appeal from a decision of the Tribunal on an issue of law to the High Court, and also by way of Judicial Review, but not on issues of fact by way of rehearing.

7.12 The current ability of the Authority to permit trial periods of leave of absence of a detained patient subject to conditions should be extended to permit the Tribunal to direct likewise. (At present the Tribunal's power is restricted to making a recommendation the patient be granted leave of absence with a view to facilitating discharge at a future date).

7.13 If it is recommended that the legislation should enable the Authority to grant a conditional discharge it is recommended that the Tribunal should similarly be empowered to order conditional discharge of a patient subject to recall by the Authority to detention in hospital for treatment if conditions are not met by the patient in the opinion of the multi-disciplinary team. If recalled the Authority should be required to refer the patient to the Tribunal within 28 days of return unless within that period the conditional discharge has been reinstated.

7.14 The Authority must satisfy the burden of proof to adduce evidence that justifies continuing detention in hospital for medical treatment, or continuance of guardianship, in accordance with statutory criteria, otherwise the patient must be discharged. The statutory criteria to be considered by the Tribunal must always be the same criteria the Authority must consider to justify a decision to admit for assessment, or to detain for treatment, or to admit into guardianship. The discretionary power of the Tribunal to discharge a patient in any case should be preserved.

7.15 Hearings should continue to be held in private, unless otherwise ordered, in compliance with the right to respect for private life.

7.16 The Tribunal should not have power to impose a care plan, other than in accordance with provisions regarding a conditional discharge.

7.17 A Code of Practice may include a provision that members of nursing staff may give evidence at the hearing before the Tribunal, at the instance of the patient and/or the Authority and of the Tribunal.

7.18 The social circumstances report to the Tribunal should be prepared and written and submitted at the hearing by an Approved Social Worker. The form and content of the report to the Tribunal should be included in Professional Guidelines and/or a Code of Practice, but not in legislation.

7.19 The form and content of the RMO's evidence report to the Tribunal should be included in Professional Guidelines and/or a Code of Practice, but not in legislation.

7.20 The concept and current description of a nearest relative is undesirable. Current rights of a nearest relative could infringe human rights provisions for respect for the private life of a patient. The present category of nearest relative does not permit inclusion of anyone other than a relative except in very restrictive circumstances and there are frequently others who have a closer connection to the patient in the community than a blood or marital relative. The concept of granting rights of review/interference to a person with relevant and close interest in the welfare of the patient in the community, in addition to members of the medical or social work professions, while desirable, may infringe Human Rights provisions. An acceptable compromise may be achieved by providing for the right of such persons who have the closest connection or affinity with the patient while in the community to be consulted by members of the multi-disciplinary team to ascertain and consider the views of the person consulted, and to report such views to the Tribunal in the social circumstances report.

7.21 A Code of Practice should advise that medical and nursing notes routinely be made available to the medical member of the Tribunal who will report on relevant contents to the other members who also should also have access to them. The Code of Practice should also provide that these records be available to the representative/patient except in so far as specific disclosure to the patient would cause serious harm to the patient's health or put at risk the safety of others, in which case the records should be available to the representative alone upon an undertaking not to disclose the contents to the patient.

7.22 The patient should continue to be empowered to have an independent medical examination and assessment, and records should be available to the independent examiner. The Tribunal should be empowered to direct that additional evidence should be obtained, including independent medical examination and written and oral report which should be disclosed to the parties

7.23 The current requirement for informality in the Tribunal proceedings should be preserved.

7.24 Venue of proceedings could be governed by a Code of Practice to the effect the venue should ensure privacy. It would not be practicable or desirable to have proceedings relating to a detained patient conducted in an independent venue located elsewhere than in the hospital where the patient is detained.

7.25 The decision of the Tribunal should be in writing, and should be supplied to the patient, to the patient's representative, and to the Authority. The reasons for the decision should be separate and in writing, and should normally also be supplied to the patient, to the patient's representative, and to the Authority except in special cases where it is determined that disclosure to the patient or to others would cause serious harm to the patient's health or put at risk the safety of others, in which case the written reasons should be withheld from the patient or the others so specified, but should nevertheless be disclosed to the patient's representative and to the Authority.

7.26 The decision of the Tribunal is by consensus on the basis of evidence adduced. Whether or not to record the decision is by a majority is for the President to decide, but the reasons for a minority decision should not be recorded. The reason for the

decision must be recorded, but legislation should not require a minority decision to be recorded.

7.27 Amendments to the Tribunal's powers and duties should be effected by a repeal of existing legislation with re-enactments of existing provisions where appropriate, rather than amendment by substitution into and reference to the present legislation, because clarity and ease of reference are particularly important when the provisions affect those with a mental disorder or a learning disability.

8. Responses to the Recommendations of the Northern Ireland Human Rights Commission's December 2003 Report Relating to the Mental Health Review Tribunal

The contents of the Report and Recommendations therein disclose that in some material respects the authors were not conversant with some of the powers duties practice and procedure of the Mental Health Tribunal of Northern Ireland in respects which appear in the following responses to all of the numbered recommendations, which are italicised:

8.1 That "*An automatic review of detention decisions by an independent tribunal should be introduced. This review must take place at the earliest opportunity and within 28 days*":

- It is inappropriate for any Review Tribunal in effect to decide on whether a patient can or should be detained after assessment, rather than to review a decision already taken and based on clinical judgment. See the Recommendations at paragraphs 7.5.2, 7.5.3, 7.5.4, 7.5.5, 7.5.8, 7.5.9, 7.8, 7.9, 7.13 and 7.15, which would sufficiently protect the rights of the patient.

8.2 That "*Rigid restrictions should be lifted on applications to the tribunal to allow further applications if a change in circumstances can be shown on the face of the application*".

- This proposal is unworkable in practice, because every detained patient could apply following a Tribunal decision with which the patient disagreed, and on the face of the written application assert a change in circumstances such as "I am feeling better now than previously and promise to take my medication if discharged". A reduction from the current periods during which applications and references can be made as suggested in paragraph 7.5 is sufficient. Furthermore the Authority is under a duty to discharge a patient if and when any of the criteria for detention are not satisfied.

8.3 That "*There should be increased resourcing of the tribunal system together with a time limit within which a hearing can be expected to be heard in order to tackle delay.*"

- In principle agreed, with the caveat that there is no evidence that there is delay in fixing Tribunal hearings in Northern Ireland. Furthermore no complaints concerning perceived delay in the current system, in which hearing dates are fixed in 5 to 8 weeks, at most, from receipt of an application have been received from the user groups, which were consulted – see paragraph 6 in particular. A

fixed time limit could be too long in some circumstances and not long enough in others, but increased resources are to be welcomed in order to prevent delay, and should include resources for the Authorities in addition to the Tribunal. The reason for the lapse of 5 to 8 weeks between the date of application or referral and the hearing is to enable the Authorities to prepare the written evidence, which often is unavailable until shortly before the hearing.

8.4 That "*There should be funding for specialist independent and accessible mental health legal advice and representation. This should include children and should take account of their particular needs. Advice and representation funding needs to take account of the need for translation and interpreting services for those from minority ethnic backgrounds.*"

- Agreed – see paragraphs 7.9 and 7.10. Translation and interpreting for minority ethnic background persons in Northern Ireland is rarely if ever experienced at Tribunal hearings, and in any event is not within the ambit of a Tribunal's jurisdiction but is a matter to be arranged by the relevant Authority.

8.5 That "*Greater transparency should be introduced to the role of the medical member by requiring the disclosure to the parties of the basis upon which the opinion is given.*"

- Already adopted in the current system – see paragraph 3.12; and also the recommendations at 7.4.

8.6 That "*The current burden of proof at tribunal hearings should be reversed as required by the ECHR*".

- Currently the Tribunal in Northern Ireland has always placed the burden of proof to establish the criteria for detention upon the Trust – see paragraphs 3.1, 3.12 and 5. However, the legislation has now been drafted in clearer terms to specify this in Northern Ireland.

8.7 That "*The tribunal rules should be amended to meet UN standards on the withholding of documentation from patients.*"

- Agreed that the current test (that reports and other documents may be withheld if their disclosure would be damaging to the health or welfare of the patient or other persons should be changed to the UN standard: "*Full disclosure of documentation should be made except in special cases where it is determined that a specific disclosure to the patient would cause serious harm to the patient's health or put at risk the safety of others*" – see paragraphs 7.7 and 7.21.

Professional Guidelines and Codes of Practice should advise that the RMO and Approved Social Worker should be informed by the Trust that copies of the reports would be issued to a patient who does not have a legal representative, unless the report includes the caption to the above effect.

8.8 That "*Consideration should be given to the provision of independent premises for the MHRT.*"

- Consideration of this recommendation discloses the necessity of travel arrangements from the hospital in which a detained patient is located to other premises for patient's doctor's nurses and social workers ancillary staff and other witnesses. The consequent disruption this would cause to the care and welfare of other patients in the hospital, precludes adoption of this proposal – see paragraph 7.24.

8.9 That *"A free statutory aftercare duty should be introduced as in England and Wales, together with funding, in order to allow discharge by the tribunal without delay on the grounds of inadequate care arrangements."*

- Agreed, although the abolition of the duty in England and Wales, which is not an absolute duty, is under review.

8.10 That *"Monitoring should be carried out of the experience of tribunal users from a minority ethnic background and all other section 75 groups to assess whether there is evidence of unequal treatment and to ensure any access and communication issues are being adequately addressed, for example the provision of sign language interpreters."*

- May be desirable elsewhere in the United Kingdom, but there is no evidence that this is required in Northern Ireland and Tribunal users thus described have not been identified to date. In any event this is not a matter to be properly included within the legislation, which is to govern the jurisdiction of a Review Tribunal.

8.11 That *"Equality training should be provided for all those involved in the tribunal system."*

- This is not a matter for legislation but may be included in Professional Guidelines and/or a Code of Practice. Note that this recommendation is not confined only to Tribunal members, but also includes all psychiatric nurses, all doctors in psychiatric hospitals, all approved social workers, all community psychiatric nurses, all carers, and all staff in residential psychiatric care establishments.

8.12 That "*Specific provision should be made for children and young people within mental health legislation.*"

- The detention of children may be arranged under the Children (Northern Ireland) Order 1995, which does not provide the safeguards provided under the Mental Health (Northern Ireland) Order 1986, but this is not a matter specifically to be within the jurisdiction of the Tribunal, although the powers and duties of the Tribunal should reflect any mental health provisions concerning children in this regard - see paragraph s 7.5.5, 7.9 and 7.10.

8.13 That "*Children and young people should be afforded a right to an automatic review of detention."*

- See paragraphs 7.5.5, 7.8 and 7.9.

9. References

- The Mental Health (Northern Ireland) Order 1986
- The Mental Health Review Tribunal (Northern Ireland) Rules 1986
- The Mental Health (Amendment) (Northern Ireland) Order 2004
- The Mental Health (Northern Ireland) Order 1986 Code of Practice
- The Mental Health (Northern Ireland) Order 1986 Guide
- The Mental Health Review Tribunal for Northern Ireland Annual Reports for years ended March 2001, March 2002, March 2003
- Northern Ireland Human Rights Commission Report "Connecting Mental Health & Human Rights" December 2003, chapter 3.
- Report on the Review of the Mental Health (Scotland) Act 1984 "New Directions"
- "New Directions" Executive Summary
- Submissions from Stakeholders April 2003
- Overview of the Mental Health Review Tribunal 20 August 2003
- Questionnaire for responses on Consideration of the Role of the Mental Health Review Tribunal 22 October 2003
- Minutes of the Meeting of the Mental Health Users Reference Group 31 March 2004
- Submission from J L James 21 February 2006
- Patients' Advocate Submissions April 2004.
- British Journal of Psychiatry (2000, 176, 110-115 - "Doctors on Tribunals".
- Journal of Australian and New Zealand Association of Psychiatry, Psychology and Law, Vol. 10 No 1 2003 – "Mental Health Tribunals and Decision-making".