

Mental Health Tribunals

Current law

Mental Health Review Tribunals (MHRT), comprising of three members, deal with applications and references in respect of patients subject to the provisions of the Mental Health Act, including those subject to compulsory admission to hospital and guardianship. Each Tribunal must consist of a legal member; a medical member (i.e. a registered medical practitioner), and a member with relevant experience (e.g. a knowledge of social services).

Tribunals have the power to discharge unrestricted people from hospital if they are satisfied that the patient is not suffering from a mental disorder of a nature or degree which warrants his/her detention, or their detention cannot be justified under Section 72 of the 1983 Act.

Hospital Managers have the power to discharge unrestricted people, the power being exercised by three or more members of a committee set up for that purpose under Section 23 of the 1983 Act. Tribunals have limited powers to discharge restricted people under Section 73 of the 1983 Act.

Article 6 of the European Convention on Human Rights, which was introduced into English Law by the Human Rights Act 1998, provides for a right to a fair trial, which includes the right to:

- a fair hearing
- a hearing before an independent and impartial tribunal
- a hearing within a reasonable time.

Patients have free legal representation at Mental Health Review Tribunals.

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

The Act provides for a Mental Health Tribunal for Scotland with a right of appeal to the Sheriff Principal and a further right of appeal to the Court of Session.

Tribunals will comprise a legally qualified Chair; a qualified person in medicine and the diagnosis and treatment of mental disorder; and a person qualified or experienced in providing services to people with a mental disorder.

The role of the Tribunal is to consider whether the conditions for continuing treatment under compulsory powers are met and to authorise a treatment order, which may specify the detention of a patient in a specified hospital or to reside at a specified place.

The responsible medical officer will have power to revoke a compulsory treatment order.

The Draft Mental Health Bill 2004

The Draft Bill proposes to abolish the Mental Health Review Tribunal system and replace it with the Mental Health Tribunal (MHT) for England and Wales. There will be a President of the Tribunal appointed by the Lord Chancellor and the function of hospital managers in respect of reviewing detention will be abolished.

Under the new system, hearings can be conducted by panels of one, two or three members chosen by the President of that Tribunal. Single member sittings will only be used in circumstances set up in Rules and would include, for example, failure to appoint a nominated person and technical, procedural or preliminary matters.¹

MHT members must fall within the following categories:

1. Legal members – who must always be included and will chair the MHT
2. Clinical members – i.e. a person with knowledge or experience of the treatment of mentally disordered people (which will include psychiatry, nursing, psychology and other clinical specialisms)
3. General members - i.e. a person with knowledge or experience of providing mental health services.

The main functions of the MHT will be to provide legal authority for compulsory treatment beyond 28 days following applications by the clinical supervisor; and to review patients' cases following applications by the patient, their nominated person and, if the patient is under 16, any person with parental responsibility. The main powers of the MHT will be to discharge the patient from compulsory powers if the relevant conditions are not met, make orders for assessment or treatment and approve the care plan, and determine whether patient should be detained in hospital as a resident patient or dealt with in the community as a non-resident patient.

An application by the patient or nominated person for discharge or change of status to a non resident patient can be made at any time after the patient becomes liable to assessment. The clinical supervisor may bring forward an application for a treatment order so that both applications are dealt with at the same time. Applications to discharge the treatment order can be made once after 3 months but further applications may be made with leave of the Tribunal. Applications to change the status of the patient from resident to non-resident can be made at any time and once before the end of the order. Further applications may be made with leave of the Tribunal.

Hospital managers must ensure that the clinical supervisor makes an application to the MHT for an order authorising medical treatment or further assessment within 28 days. The order for medical treatment may not exceed 6 months. This may be followed by two further orders for up to 6 months and, after 12 months or 3 consecutive orders, a further order can be made for up to 12 months. The clinical supervisor is required to consult the nominated person and any informal carer before an application is made to the MHT.

The clinical supervisor must apply to the Tribunal for the variation of an assessment order or treatment order. The clinical supervisor can grant leave of absence or, in the case of a non-resident patient, suspend any of the conditions imposed on the patient.

¹ Department of Health, 2004. *Improving Mental Health Law – towards a new Mental Health Act*. Paragraph 9.31

The Tribunal will be advised by an independent medical expert drawn from the Expert Panel in all cases involving patients who are detained in hospital as a resident patient or subject to conditions as a non-resident patient. The Tribunal may also appoint other members of the Expert Panel, who may or may not be registered medical practitioners, to provide advice. The panel will include doctors drawn from a variety of backgrounds, including from black and ethnic minorities. It will also include people with experience of ethnic minority issues, social care, learning disability nursing, mental health nursing and the probation service.

The Tribunal can reserve to itself the power to discharge a patient from assessment or treatment orders and to approve applications for a patient to be transferred or given leave of absence. The reasons for this are to be set out in regulations and the intention is that this power will only be available where a patient poses a significant risk of causing serious harm to others.²

There is a duty on the Tribunal to make a 'deferral order' when the Tribunal makes a discharge order in relation to a patient who has been detained for at least 28 days and there is no discharge plan in place, and without after-care the patient is likely to meet all the necessary conditions within 8 weeks. This gives the managers up to 8 weeks to detain the patient in order that a post-discharge care plan can be provided.

The Tribunal also has powers to:

- authorise ECT for adult patients under formal powers who lack capacity to consent or refuse treatment, and for all children under 16
- determine if a child under 16 entitled to special safeguards is lawfully detained
- resolve disputes involving children under 16 entitled to special safeguards where there is disagreement about the approval or review of a care plan
- deal with the appointment or removal or revocation of nominated persons

A Mental Health Appeal Tribunal (MHAT) will provide a second tier of appeal from the MHT on a point of law. The MHAT will comprise of a President and a number of other members who will be experienced and suitably qualified lawyers appointed by the Lord Chancellor. All appeals will be heard by a single member of the MHAT. The MHAT will not be able to discharge patients but it can give recommendations as to the timing of reconsideration of the case by the MHT and it can direct that medical treatment may not continue until the determination by the Tribunal on reconsideration of the case.

Recommendations of the Joint Committee on the Draft Mental Health Bill

The Committee made the following recommendations:

1. That the MHT be given power to order the transfer and leave of absence of restricted patients.
2. That it shall be a duty of criminal court judges to consult a member of the Expert Panel when considering a care plan.
3. That the Government expedite the completion of its studies into the expected length of hearings under the Bill and, once these studies are complete, that the

² Department of Health, 2004. *Improving Mental Health Law – towards a new Mental Health Act*. P.9.

Government recalculate and republish the workforce and funding implications of the new system in the Regulatory Impact assessment that it presents to Parliament with the Bill proper.

4. Prior to the publication of any future Mental Health Bill and the introduction of the new MHT system, the Government should publish realistic plans detailing exactly from where the increased number of tribunal members will be drawn, and explaining in detail how the new MHT system will administer more than 40,000 hearings a year.
5. That no new Act be brought into force until the Government can demonstrate that sufficient resources are available, both financial and human, to allow for the proposed extensions in hearing numbers and remit.
6. That in the interests of ensuring that hearings are both fair and seen to be fair, there be a clearer distinction between the roles of the MHT as a detaining body and as a review tribunal. So, for example, a member of a tribunal that has imposed an order for assessment or treatment should never hear the review or appeal of that order.
7. That the current discretion in Section 72 of the 1983 Act, which permits the MHRT to discharge patients even where the detention criteria are met, be included in the Bill.
8. That, in order to ensure a fair hearing, the MHT, when hearing substantive matters and sitting as a panel, sit only as a panel of three members. The Joint Committee stated that a MHT should be permitted to sit with fewer than three members at case management hearings and it would be wholly inappropriate for a single member panel, consisting of a lawyer sitting in a judicial capacity, to decide substantive clinical issues.
9. That Clause 249 of the Bill should also include provision for NHS Trusts to appeal to the MHAT on a point of law.
10. That the Bill include a requirement on the MHT, when examining care plans, to consider wider concerns and considerations than purely medical matters – e.g. social and housing needs.

Alliance position

The Alliance supports the general principle that compulsory powers should be exercised beyond an initial period without an order from the newly-constituted MHT. However, we are concerned that the proposals contained in the draft Bill will fail to effectively safeguard the rights of people who are being detained or treated under compulsory powers. We therefore recommend a number of changes to the proposed MHT framework.

Our key concerns are that:

1. Tribunal membership is dominated by the medical profession and does not provide for the inclusion of people who have experienced mental illness nor of women and people from black and minority ethnic communities;
2. Tribunals should not be able to reserve to themselves the power to discharge patients from compulsory orders;
3. The Bill creates a disincentive for patients to appeal against their initial assessment order because this may result in the making of a long term treatment order;

4. Appeals against the use of compulsory powers should not be heard by the same Tribunal that authorised the order;
5. The scope of the care plan to be considered by the Tribunal is too narrow;
6. The Tribunal lacks the power to amend care plans in the face of objections from the clinical supervisor;
7. The Tribunal should retain discretion to discharge civil patients, even where the conditions for the use of compulsory powers are met;
8. The Bill fails to provide clear grounds for the Tribunal when determining whether compulsory treatment should be imposed in the community;
9. The proposals for Deferral Orders are unrealistic and potentially unlawful;
10. The Tribunal should be given the power to discharge and to order the transfer and leave of absence of restricted patients;
11. There must continue to be a right to publicly funded legal representation for MHT hearings; and
12. We share the concerns that the new Tribunal arrangements are likely to be unworkable.

Membership of the MHT

The Alliance believes that each MHT should comprise:

- a. a legally qualified member;
- b. a member with experience of providing mental health services, but not a doctor (the MHT should be advised by an independent doctor from the proposed Expert Panel);
- c. a lay member, who may be a person who has experienced mental illness, an informal carer or someone who represents their interests; and
- d. a children's professional where the patient is a child or young person.

Schedule 2 of the draft Bill states that the new Tribunal should consist of a legal member, a clinical member- defined as a person who has, "*such knowledge or experience of the treatment of mentally disordered persons as the Lord Chancellor thinks fit*" - and another member with such experience who is not a legal or clinical member.

Tribunals should require a 'professional member'

We do not agree with the requirement that the Tribunal must have a clinical member. The MHT is required to make a legal decision which is likely to have significant medical and social consequences. Medical input is already provided by an independent doctor from the Expert Panel. We therefore suggest that membership of the MHT should include a 'professional member' from outside of the medical profession, for example a social worker, occupational therapist or mental health housing worker.

The automatic inclusion of a clinical member will also lead to hearings being based exclusively on the medical model of mental health care: the MHT will contain a clinical member; it is advised by a doctor from an Expert Panel; and the clinical supervisor or junior doctor will attend the Tribunal hearing. This would place too much emphasis on medical views to the detriment of the views of the person whose case is being considered. To have a doctor as a member of a Tribunal would also lead to conflict between their role as an expert and as a decision-maker. We are also aware of the severe practical difficulties in recruiting medical members under the existing Act; this will be even harder under the proposed Bill.

We acknowledge however that there may be circumstances in which a doctor could be a member.

As Mike Shooter of the Royal College of Psychiatrists put it: "*It has never been the assumption of the Royal College, either individually or as part of the Alliance, that there had to be a medical member on the Mental Health Tribunal, as long as the tribunal is in receipt of expert evidence*

from a medical member of the Expert Panel... We are moving into a situation with new ways of working where other members of the mental health team may well have very highly skilled and trained clinical expertise which they could give to a Mental Health Tribunal.”³

The Mental Health Alliance supports the proposal of the Expert Committee, which suggested that as a way of achieving the necessary independence and expertise, while reflecting the demands of fairness and the realities of consultant ability, Tribunals should not contain a medical member, i.e. a doctor, but have access to independent medical advice.

Tribunals should include service users and carers

We are concerned that the proposed membership of Tribunals does not explicitly include people who themselves have experienced a mental illness or others who may have a lot to offer in terms of their experience of mental illness and mental health services. As a matter of principle the lay member of the Tribunal should be a person who has experience of mental health services as a user or carer, or a volunteer or employee who works with and can represent any of these groups. This would be consistent with, for example, employment tribunals, which contain representatives of both management and employees.

Tribunals should reflect the culture, language and beliefs of the patient

Membership of the MHT does not specifically include people from black and ethnic minority groups and we believe this is crucial to ensure that the Tribunals are able to take full account of a person's culture and circumstances, e.g.:

- the degree of involvement with both the culture of origin and the host culture, taking special recognition of language abilities and preferences
- the predominant idioms of distress through which symptoms or the need for social support are committed, e.g. possessing spirit, somatic complaints, inexplicable misfortunes
- culturally relevant interpretations of social stressors, social support, levels of functioning disability
- cultural elements of the relationship between the individual and the clinician and the problems these may cause in diagnosis and treatment.

We therefore recommend that Tribunals should include BME representation where appropriate. This is especially important considering that under the 1983 Act African-Caribbean people are more likely to be detained and receive higher doses of medication than the population as a whole. We recognise and welcome the inclusion of people with experience in ethnic minority issues on the Expert Panel but there is a danger that such issues will be seen to be of secondary importance or treated in a superficial way unless Tribunals include BME representation.

Tribunals should reflect the gender of the patient

Tribunals should also specifically contain at least one person of the same gender as the person whose case is being heard. There are particular gender issues to consider including, in respect of medication, sexual functioning, menstruation and risks to a foetus during pregnancy.

³ Dr Mike Shooter, Royal College of Psychiatrists, on behalf of the Mental Health Alliance, November 2004. *Report of the Joint Committee on the Draft Mental Health Bill: Volume II, Ev.162-3.*

Tribunals should not be able to reserve to themselves the power to discharge patients from compulsory orders

Clauses 46(5) and 49(5) provide that the Tribunal can reserve to itself the power to discharge, transfer or grant leave of absence to certain patients to be defined in regulations. No clear definition is offered as to who this will cover, however the explanatory notes provide the following example:

“A patient with a long history of schizophrenia and violent behaviour gets a new clinical supervisor when a former clinical supervisor retires. The new clinical supervisor takes a different view about the nature of the patient’s condition and decides that the patient no longer meets the relevant conditions and discharges him or her. The patient then comes under formal powers again a couple of weeks later, having attacked someone, and an application is made for a treatment order. The Tribunal might be concerned that the clinical supervisor’s view of the patient’s condition could result in the patient inappropriately being discharged and would then reserve discharge to itself.”⁴

We are concerned that such an extreme example is being used to justify the creation of a new legal power which could potentially lead to patients being detained even though they no longer meet the relevant conditions for compulsion. The prospect of the clinical supervisor losing control over the care of some civil patients, who will in effect be treated as if they were under a restriction order, is wrong in principle and may violate Article 5 of the European Convention on Human Rights (ECHR). The role of the Tribunal should be to authorise orders and determine appeals against compulsion and should not include consideration of whether to discharge an order in circumstances where a clinician decides that it should end.

People should not be discouraged from appeal within the first 28 days

If the patient appeals within the assessment period, the Tribunal could convert the assessment order into a treatment order. This may be seen as a disincentive to appealing during this period.

The Draft Bill makes it possible for the Tribunal to hear both the appeal against compulsion and an application for a treatment order concurrently. Necessarily, many patients will be wary of challenging their detention, given the purpose and possible consequences of the hearing. This weariness is likely to be reinforced by the fact that their perception of Tribunals will change. Instead of being the independent body that can order their release, it will be seen as the authority that imposes long-term compulsion. It is still doubtful that these provisions satisfy Article 5 of the ECHR.

This proposal would also have a disproportionately negative impact on the vast majority of patients under the 1983 Act who are detained but then discharged or made informal before 28 days. Under the draft Bill these patients would not get an automatic Tribunal and would be deterred from appealing against their detention at an early stage for fear of the MHT imposing a long term treatment order.

The Alliance believes that where a person appeals against an assessment order, the Tribunal should not be empowered to authorise a treatment order.

⁴ 2004. *Draft Mental Health Bill Explanatory Notes*. p26, Para 121

Appeals against the use of compulsory powers should not be heard by the same Tribunal that authorised the order

The Alliance is concerned at the blurring of the functions given to the Tribunal as a detaining authority, and a review body. This raises questions about the impartiality and independence of the Tribunal when it is responsible for authorising detention and then subsequently acts as a reviewing body on an application by a patient. This would potentially engage Article 6 of the ECHR which provides a right to a fair trial by an independent and impartial court.

The Alliance believes that appeals against a compulsory order should not be considered by the MHT that authorised the order. Instead they should be considered by a differently constituted Tribunal and a member of the Tribunal that imposed an order for assessment or treatment should never hear the review or appeal of that order.

The scope of the care plan to be considered by the Tribunal is too narrow

We welcome the requirement that the clinical supervisor must produce a care plan for each Tribunal but are concerned that its scope will be very narrow, consisting primarily of the medical treatment which may be given in the absence of consent. Clause 39 of the draft Bill states that the contents of the care plan must include a description of the medical treatment and other information which will be laid down in regulations. This contrasts with the approach taken in the White Paper which proposed that the care plan would be modelled on the Care Programme Approach and we regret that this has been dropped. The narrowness of the care plan may mean that the Tribunal is inadequately informed to make decisions required of it, and it also renders the duties placed on the clinical supervisor to consult the patient, carer and nominated person to be of limited value.

We believe that the care plan must be holistic and include comprehensive reference to all the health, psychological, occupational and social needs of the patient; and that the statute itself should specify that this must be accordance with the Care Programme Approach.

The Tribunal lacks the power to amend care plans in the face of objections from the clinical supervisor

It is apparent that the new MHT will be much more involved in the approval of treatment plans than the current MHRTs. However the Tribunal appears to have no power to order the clinical supervisor to change the proposed treatment plan; only such amendments as are 'agreed' with the clinical supervisor may be made. It is also not clear what the position would be where agreement cannot be reached between the Tribunal and the clinical supervisor. This could present particular difficulties in the case of a resident patient who the Tribunal considers could be treated more appropriately in the community.

The Tribunal may have misgivings about the clinical supervisor's decision as to the appropriate treatment and this view may be shared by the Expert Panel member. However, it appears that the only options would be persuasion or the extreme step of refusing to authorise the entire treatment order. We accept that a clinical supervisor cannot be required to administer treatment which s/he thinks is not therapeutically appropriate, but we believe that as a matter of principle the Tribunal should be able to block specific treatment which it is satisfied is not in the patient's interests. Otherwise it is difficult to see that the role of the Expert Panel member would be of great value. This would ensure that the MHT provides sufficient judicial oversight compatible with Article 6 of the ECHR.

The Tribunal should retain discretion to discharge civil patients, even where the conditions for the use of compulsory powers are met

In contrast to the 1983 Act, the Draft Bill removes any discretion for the Tribunal so that, once the criteria are met, compulsion must follow and the Tribunal is unable to take into account matters not referred to in the Government's test. We believe that the removal of this power will undermine the Tribunal's potential as a genuine safeguard and the effect would make it more likely that those who did not require compulsion would be compelled to receive treatment. Indeed, under the Draft Bill there is a greater need for a discretionary power because the broadly drafted relevant criteria ensure that patients would easily fulfil them and this will limit the ability of a Tribunal to discharge a patient. The Alliance therefore recommends that Tribunals should continue to have a discretionary power to discharge people from compulsion.

The draft Bill fails to provide clear grounds for the Tribunal when determining whether compulsory treatment should be imposed in the community

The draft Bill fails to provide clear grounds for the Tribunal when determining whether compulsory treatment should be imposed in the community. The draft Bill provides no additional threshold criteria for the MHT to determine whether compulsory treatment is to be imposed in the community as a non-resident patient, or under conditions of detention as a resident patient. The relevant conditions in Clause 9 require only that the threshold for treatment under compulsion be reached but no additional threshold criteria is required in deciding whether the patient is to be a resident or non-resident patient. The same criticism may be made of mental health orders imposed by the Crown Court. This is likely to be incompatible with Article 5(1) of the ECHR. A contrast may be made, for example, with Clause 147(6) which sets criteria for the Tribunal when considering a non-resident order on a restricted patient.

The Alliance is concerned about the Government's proposals for compulsory treatment in the community and we believe that there is a sufficient evidence base to justify rejecting the proposals in this Bill. These proposals, combining community orders with a wide definition of mental disorder and loose criteria, in an environment in which community services are insufficiently developed and defensive professional practice persists, will not work. The Joint Committee agrees with this stating:

*"Non-residential compulsion could be applied to a far wider population than is appropriate, and in circumstances which could be unacceptable."*⁵

However, given the Government's commitment to Non Residential Orders (NROs), the Alliance as a whole has agreed on a minimum set of requirements that would be necessary before any form of NROs could be viewed as acceptable and workable. This would include providing clear grounds for the Tribunal to determine whether to change the status of the patient from resident to non-resident. For example, the Bar Council has suggested criteria to the effect that the patient must be treated/assessed as a non-resident patient unless the Tribunal is satisfied that treatment can only be given in hospital, and it is necessary for the health or safety of the patient or the protection of the public from harm that he receive the treatment as a resident patient.

⁵ 2005. *Report of the Joint Committee on the Draft Mental Health Bill*, Volume I, p.70, para.197.

The proposals for Deferral Orders are unrealistic and potentially unlawful

Where a detained Part 2 patient does not meet the relevant conditions for compulsion in the community, the MHT must in some cases authorise her/his detention for a further eight weeks under a deferral order. This applies where no post-discharge care plan has been prepared by the managers of a hospital or relevant local authority, and where all the relevant conditions will be satisfied within eight weeks if the patient is discharged without post-discharge services.

We are concerned that under this provision a Tribunal would be able to authorise a person's further detention for up to eight weeks when it has just determined that he/she does not satisfy the relevant conditions for compulsion, let alone detention. It is of further concern that this decision will also be based on the Tribunal performing the near impossible feat of projecting 8 weeks into the future to determine whether or not, in the absence of a discharge plan, all the relevant conditions are likely to be fulfilled. This is unlikely to be a precise exercise even in cases with a history of deterioration.

In the absence of a duty on the relevant authorities to provide such services, or a power in the Tribunal to compel such provision, a deferral order is likely to be unworkable, with the consequence of an unreasonable delay in achieving discharge, which would be in violation of Article 5(1)(e) of the ECHR.⁶ There is also no indication of what should happen in the event that it takes longer than 8 weeks to organise post-discharge services. The performance of post-discharge planning and the availability of suitable post-discharge services are real issues currently affecting the conduct of Tribunals.

It is also worth pointing out that the deferred discharge regime envisages that a patient entitled to discharge and who is unlikely to deteriorate within a short period of discharge, be discharged immediately regardless of the availability of a post-discharge plan. We believe there is no difference between a patient likely to deteriorate within 8 weeks and one who is not, in that both should be entitled to post-discharge care.

The Tribunal should be given the power to discharge and order the transfer and leave of absence of restricted patients

The Draft Bill provides that a restricted patient can only be discharged, given leave of absence, or transferred to another hospital with the agreement of the Home Secretary. The Alliance believes it is essential that the MHT makes these decisions.

We believe that the Bill should provide an enforceable right to treatment in the least restrictive environment which is consistent with the needs of the patient and the need to protect the public.

The problem of patients stuck in inappropriately high conditions of security is longstanding⁷, and while we welcome Government policy to increase the provision of medium and low secure facilities, we consider that these decisions are of such importance to the individual's liberty that they should lie in the hands of the MHT. We concede that Article 5(4), as currently interpreted, does not require the Tribunal to have jurisdiction to take such essential decisions.⁸ Nevertheless, detention of a patient in inappropriate conditions of security may violate their rights under Article 8 of the ECHR. The Tribunal is best placed to make decisions about the level of security a patient requires having heard

⁶ Johnson v UK (1997) 27 EHRR 296

⁷ Department of Health, February 2000. *Report of the Review of Security at the High Security Hospitals.*

⁸ Ashingdane v United Kingdom (1985) 7 EHRR 528

all the medical evidence with representations from the patient, and it is both wasteful and unjust not to allow the Tribunal to act upon that information.

We support the recommendation of the Expert Committee that the Tribunal should have power not only to order a restricted patient's discharge but also to order such steps as are a necessary precondition to the patient being discharged, in particular a power to order transfer between hospitals and leave of absence.

There must continue to be a right to publicly funded legal representation for MHT hearings

People subject to compulsory powers will have the right of access to independent advocacy services under the draft Bill but also need publicly funded legal representation at MHT hearings in accordance with Article 6 of the ECHR. Publicly funded representation is provided for MHRT representation under the 1983 Act and it also needs to be made explicit that this will continue to be the case at both MHT and Mental Health Appeal Tribunal hearings, given the human rights issues that they need to consider.

The new Tribunal arrangements are likely to be unworkable

We share the widely held concerns over the practicability of the new arrangements. There will be a significant increase in the number of Tribunal hearings. There will also be a vast expansion in the types of decisions that Tribunals will be empowered to consider, such as; authorising care plans, displacing nominated persons, authorising ECT and examining whether the relevant conditions apply. This will require a huge change in the culture of Mental Health Tribunals. It is likely that hearings will be significantly longer because they will have to consider care plans as well as issues related to compulsory powers and there will be massive implications for recruitment and training. The present MHRT system is struggling to manage the present system with appeals being cancelled and delayed. Delays in tribunal hearings as a result of the over-burdened, under-resourced system as it exists have been found to violate the article 5(4) requirement of a "*speedy review*", entitling some patients to compensation⁹. We have grave concerns about whether the new expanded system is realistic and practicable. The draft Bill fails to explain how the MHRT administration, which is currently unable to deliver an effective service, will be able to deliver the new expanded Tribunal system. It is also clear from the draft Bill that the MHT is intended to play a pivotal role in protecting patients' rights; however if, as a result of these practical difficulties, the Tribunals are ineffective, the Bill's safeguards will be compromised.

⁹ R(KB) and others