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EXECUTIVE SUMMARY

CHAPTER 1 BACKGROUND TO THE RESEARCH

This research was commissioned to provide information about the operation of section 18 of the Mental Health (Scotland) Act (MH(S)A) for the review of the Mental Health (Scotland) Act.

The MH(S)A allows people to be detained compulsorily if they have a mental disorder that requires treatment in hospital, either for their health or safety or the protection of others, and they are unwilling or unable to accept this treatment voluntarily. If a psychiatrist wishes to detain a person for longer than 31 days an application must be made to the sheriff court for an order under section 18 of the Act. This allows people to be detained for up to 6 months with the possibility of subsequent renewal. Between 1 April 1998 and 31 March 1999, 1055 section 18 detentions were granted by the sheriff court.

Most applications are made by local authority Mental Health Officers (MHOs) (although nearest relatives can also make them). The application is accompanied by two medical reports: one from the patient's psychiatrist and one normally from the patient's GP. Legal Aid is available for applications to allow the patient to be represented in the hearing, but until April 2000 this was means-tested.

CHAPTER 2 RESEARCH METHODOLOGY

The primary aim of this research was to find out as much as possible about the way section 18 operates in the courts. The research was carried out between July 1999 and January 2000. One year was chosen as a focus for the study - April 1998 to March 1999. The study involved an analysis of the Mental Welfare Commission (MWC) database, which held information about these 1055 orders. This was supplemented by a survey of local authority Mental Health Officers who had been involved in these cases. More in-depth information was collected through an analysis of the case records in 3 courts and from interviews with professionals, patients and support groups with experience of the section 18 process.

CHAPTER 3 MENTAL WELFARE COMMISSION DATA

88 per cent of patients who were detained under section 18 were already in hospital when the order was granted. Nearly all of them had a mental illness; very few were said to have a learning disability. Glasgow had the greatest number of orders, followed by Edinburgh, then Fife and Aberdeen. A sample was taken of 936 cases that were discharged by August 1999. Of these, about half (52%) lasted 6 months or less. In 31 per cent of cases the section 18 expired without renewal. 57 per cent of patients were on Leave of Absence when the order was discharged and 25 per cent of patients remained informally in hospital. In this year 2005 section 18 orders were renewed.

CHAPTER 4 MENTAL HEALTH OFFICER QUESTIONNAIRE

A sample of all the section 18 applications granted in this year was taken (739 of the 1055 orders) and a questionnaire sent to the MHOs who had dealt with the cases. 522 questionnaires were returned, a response rate of 71 per cent.

Section 18 orders were split roughly equally between men and women. 76 per cent of patients were said by MHOs to be able to communicate their wishes and feelings and 84 per cent were said to understand that they were or had been subject to the section 18 order. On average, patients had been known to Social Work departments because of their mental health for 57 months. 35 per cent had been so known for 18 months or less.

In 81 per cent of cases the patient's nearest relative was said to have been involved in the application. In 79 per cent of cases this involvement took the form of discussing the application with the MHO. Only 6 per cent of nearest relatives attended court for the hearing.

27 per cent of patients were said to have been legally aided. The main reason given for patients not receiving legal aid when they were eligible to do so was that they did not contest the application (67%). 28 per cent of patients attended court; the main reason given for patients not attending was that they did not wish to (81% of non-attenders).

Patients were said to have been represented in 39 per cent of cases, nearly all of them by a solicitor, although some were said to have been represented by family members. 60 per cent of those who were represented were said to have chosen their own solicitor; in 28 per cent of represented cases, the court chose the patient's solicitor. 24 per cent of patients who were represented had a curator ad litem. The local authority was represented in 41 per cent of cases.

Oral evidence was said to have been given in 50 per cent of cases, mostly by MHOs (in 44% of cases). Other witnesses appeared in fewer cases. The patient was said to have given evidence in only 18 per cent of cases, as was the psychiatrist, while GPs appeared in 13 per cent of cases. Nearest relatives were said to have given evidence in only 3 per cent of the hearings. 27 per cent of applications were said to have been contested.

The impact of the section 18 process appeared to be very similar for both sexes. The most significant differences were that 27 per cent of men chose their own solicitor, compared to 18 per cent of women, and a curator ad litem was appointed for 13 per cent of women and 6 per cent of men.

There was a link between being represented in court and the patient's attendance at court; 76% of those who were said to have representation, attended court. However, a significant number of patients were also represented in court, but did not attend themselves. Over half the sample (52%) were said neither to have attended court nor to have been represented. In 44 per cent of cases, the patient either attended court or was represented (data was missing for the other 4%). Patients were more likely to give evidence if they were represented and the application was more likely to be contested.

The MHO data were analysed to see how the section 18 process varied across different local authority areas. Practice varied a great deal in different local authorities, particularly in the areas of patient attendance and patient representation.

CHAPTER 5 CASE STUDIES

3 courts were chosen to provide a more in-depth picture of the operation of section 18. 2 courts were in cities and the other served a mainly rural area. The researchers analysed court records from the 3 courts and conducted interviews with court personnel. The main foci of the analysis were the court process, the problems faced by the courts in administering the Act and the brevity and content of the medical reports written on the court forms. Court personnel suggested that for them, one of the biggest challenges was working within the statutory time-limits, which leave little time available to the court or the patients to prepare for these applications.

Court A is a large urban court that hears applications from several local authorities and hospitals. The court reported no difficulties in administering the Act, possibly aided by the ease with which hearings can be placed before a sheriff on any day of the week. In roughly a third of cases, the patient had fewer than 3 days' notice of the hearing.

The patient was definitely represented in about half of all cases (though data were missing and this figure could have been higher) with a curator ad litem appointed in just 3 cases. Patients attended court in about a third of cases (again data were missing) and in nearly two-thirds of cases no oral evidence was heard. Continuations were widespread, occurring in half of all the cases looked at, mainly to obtain an independent psychiatric opinion. However, few of these reports appear to have been seen subsequently by the court.

Non-compliance with medication or treatment was given as a reason for the detention in over half of all psychiatrists' and GPs' reports. Lack of insight was given in about a third of reports. Risk to others or to self was mentioned in less than 20 per cent of doctors' reports. Just under a third of doctors' reports were very brief (12 words or fewer).

Court B is an urban court that hears applications from one large local authority and mostly from one local hospital. A highly efficient hospital administrator and close relations between court and hospital ensured that there were no major problems in administering the Act. In just under a half of all cases, applications came into the court when the section 26 order was due to expire in 4 days or less. In just over a quarter of cases the patient was given fewer than 3 days' notice of the hearing.

18 per cent of patients were represented by a curator ad litem and solicitors or curators ad litem were appointed to act for patients in just under 40 per cent of cases. Most cases were heard in hospital rather than in the courthouse. Uncontested cases were heard in chambers with only the sheriff and clerk present. Continuations occurred in just over 20 per cent of cases.

In the medical reports, non-compliance was given as a reason for the detention in just under 60 per cent of psychiatrists' reports and over 40 per cent of GPs' reports. Lack of insight was cited equally by psychiatrists and GPs in just under 40 per cent of cases. Risk to others was cited in just over 10 per cent of psychiatrists' reports and just over 20 per cent of GPs' reports. The corresponding figures for risk to self were just over 30 per cent of psychiatrists and a half of all GPs. A quarter of reports consisted of 12 words or fewer and nearly half consisted of 12 to 20 words.

Court C dealt with cases from a large, mainly rural area. The court reported the greatest difficulties in administering cases, caused in part by the distance doctors are required to travel to attend court and to visit patients. Despite this, Court C had the highest percentage of cases in which 5 to 8 days remained of the section 26 order when the application was filed. However, in just under 60 per cent of cases the patient was given less than 3 days' notice of the hearing. In a third of cases the patient was informed of the hearing the day before.

About 40 per cent of patients were legally represented but no *curators ad litem* were appointed in Court C. Patients attended the hearing in just over a third of cases and oral evidence was called in just under a quarter of cases. Continuations were used in just under a third of cases. Court C was distinguished by the relatively high number of appeals against both section 26 and section 30 orders.

In the medical reports, non-compliance with medication or treatment was cited in just under three-quarters of psychiatrists' reports and two-thirds of GPs' reports and lack of insight in just over a half of psychiatrists' reports and about 40 per cent of GPs' reports. Risk to others was cited in about 30 per cent of both doctors' reports and risk to self in 38 per cent of psychiatrists' reports and 36 per cent of GPs' reports. About a third of doctors' reports consisted of 12 words or fewer and just under 20 per cent were illegible in part or in whole.

CHAPTER 6 EXPLANATIONS

Interviews were conducted with about 50 individuals with experience of the Act from different areas. Ten of these were service users. The interviews appeared to show that there are considerable variations in practice across the country (something already suggested by the data from the MHO survey). Although the interviews were not drawn from a representative sample, they did provide some explanations for the findings from the MWC data analysis, the MHO survey and the case studies, and they offered another perspective on the section 18 process.

The interviews suggested that the section 18 process is more efficient where there are agreed procedures for filing applications and notifying patients about the hearing. This is made more difficult by doctors' lack of knowledge of the procedural requirements of the Act. The need to identify an effective treatment within the 28 days allowed by the section 26 order also appears to lead to the late filing of applications.

There were mixed views about the appropriate venue for these hearings. Patients interviewed for this study preferred cases to be heard in courts as they were perceived to be independent. Medical personnel preferred cases to be heard in hospitals because they thought they were less intimidating for patients and more convenient for hospital staff. There was some support amongst solicitors for a wider choice of venues than the court and one solicitor thought the courts should be replaced by a tribunal system.

Some solicitors expressed concerns about the brevity of the evidence provided by doctors on the court forms. One psychiatrist reported that he felt obliged to present reports to court that emphasised the patient's more abnormal behaviour, to ensure that the order was granted. GPs were reported to play a generally peripheral role in these proceedings, due to their lack of specialist knowledge of mental health.

Obtaining an independent psychiatric opinion was felt to be crucial to a successful challenge to the application. This was said to be easier to do in some courts than in others. In Court C problems were said to arise because of the difficulty of obtaining reports from doctors who live far from the court. Inevitably, the court case will be continued to allow time for an independent opinion to be obtained. According to interviewees from 2 areas of the country, doctors in their area are reluctant to treat patients during continuations. The evidence from the cases studies suggests that, in fact, independent opinions appear to have little impact on the outcome of the case. It is only in very few cases that applications are unsuccessful.

The general impression gained from the interviews was that many patients find the prospect of attending court to be an intimidating one and are too ill to take part. Some solicitors suggested that patients are deterred from seeking legal advice by medical staff. MHOs and patients reported that patients were unaware of their legal rights when they were first detained and afterwards. One interviewee had been surprised at the number of patients who appeared not to know what their rights were and had started a course in her hospital to inform them and their families.

Nearest relatives appear to play very little part in section 18 hearings. One MHO suggested that family members are protected from participating because they are under so much pressure already. There was a suggestion that family members are marginalised and do not know a great deal about their rights. One interviewee felt that many carers and relatives do not wish to have to make the decision about detaining a family member as their involvement can destroy family relationships. They would prefer a professional to make the decision. A patients' support group worker pointed out that some patients also do not want their family members to play any part in their cases because of the strains that already exist in family relationships.

Nurses were identified as being the key providers of information to patients and carers. Interviewees suggested that because they are so busy this is difficult for them, and lay advocates could fulfil this role instead. Some hospitals were reported to have good protocols to ensure that patients are given proper notice of hearings, but this is not the case everywhere. While professionals thought that they did their best to ensure that people had access to legal advice, patients and their supporters were less positive. Medical staff reported that it was difficult to inform patients about their rights because they were often too ill to absorb the information. Patients suggested that they felt they had been unlawfully detained by hospital staff and felt powerless to enforce their rights or opinions. When solicitors are involved in the case, they reported that they often have 48 hours or less to prepare for the hearing.

Psychiatrists suggested that they often do not expect patients to remain in hospital for the full 6 months of the order. Rather, patients leave hospital on Leave of Absence shortly after the section 18 order is granted.

CHAPTER 7 CONCLUSIONS AND SUGGESTIONS

The researchers concluded that the section 18 process, as designed has the potential to be independent, effective, appropriate and accountable. However, at present, the provisions designed to protect patients' rights, such as access to information and legal representation, may not work as effectively as they might.

CHAPTER 1 BACKGROUND TO THE RESEARCH

Introduction

1.1 In February 1999 a committee was set up to review Scotland's mental health legislation, chaired by former Scottish Secretary and EC Commissioner, Bruce Millan. The committee was asked to review the Act and to make recommendations about the treatment and care of people with mental disorder. This research was commissioned jointly by the Millan Committee, the Mental Welfare Commission (MWC) and the Scottish Executive Courts Group to provide all three bodies with information about court proceedings under section 18 of the Mental Health (Scotland) Act 1984.

The law

1.2 The Mental Health (Scotland) Act 1984 (MH(S)A) allows the compulsory detention in hospital of people with a mental disorder (which includes learning disability) if:

- it is appropriate that they receive treatment in hospital, and
- they are unwilling or unable to accept this voluntarily, and
- this is appropriate for their health and safety or for the protection of other people.

1.3 Under section 24 of the Act a person can be detained for up to 72 hours with the consent of either a relative or a Mental Health Officer. Under section 25, a 72-hour compulsory detention is also allowed for a patient who is already voluntarily in hospital. Once the 72 hours have expired, a patient can be detained for a further 28 days under section 26.

1.4 The patient can appeal the section 26 order to the sheriff court or ask the MWC to review the detention. If the Commission considers it necessary, it can recommend the patient's discharge.

1.5 To detain a patient for more than 28 days requires the submission and approval of an application to the sheriff court under section 18. The basis of the application is two medical recommendations, one written by a psychiatrist and the other by a GP who should be the patient's GP. Both doctors must have examined the patient personally. The application can be made by the patient's nearest relative or by a local authority MHO. The detention can last for up to six months, after which it can be renewed by the doctors for a further six months under section 30 and, thereafter, every year. As with section 26, the patient can ask the MWC to review the detention and the renewal can be appealed to the sheriff court.

1.6 The sheriff may make such inquiries and hear such people as he or she thinks fit in deciding whether to approve the application. Under section 113, the patient must be given the opportunity to be heard, either in person or through a representative. Legal Aid is available for representation in these hearings, but until April 2000 this was means-tested. Where the sheriff believes it would be prejudicial to the patient's health or treatment to be present during the hearing, the patient can be excluded. The sheriff can also hear the application in private.

1.7 The nearest relative may seek to discharge the section 18 order under section 34 but the hospital doctor can block this. Otherwise, the order can be discharged by the patient's hospital doctor or by the MWC. The patient can also be given Leave of Absence from the hospital for up to one year, even though he or she remains subject to the order.

Procedure

1.8 Within five days of the application being submitted (excluding Saturdays, Sundays and court holidays), the sheriff must either approve the application or hold a hearing. Once the application has been submitted the patient can continue to be legally detained until the hearing, even if the section 26 order has expired during this time¹.

1.9 Under the Sheriff Court Rules², if the person who is the subject of the application is not already in hospital, the application must be served on them personally by a sheriff officer. If the person is already in hospital, the application must be served on them by the Responsible Medical Officer (RMO). It may be prejudicial to the patient's health or treatment to serve them with the papers. If this is the case, two medical certificates must be presented to the sheriff setting out this opinion and the sheriff may dispense with service. A curator ad litem must then be appointed to represent the patient's interests. A curator ad litem may also be appointed where it appears appropriate. If the patient wishes to be represented but has not appointed a solicitor, the court may do this.

1.10 The Sheriff Court Rules require that a prescribed letter be sent to the doctor responsible for informing the patient of the application (the RMO). The RMO must return to the court a form stating that the patient has been informed of the hearing and stating whether the patient plans to attend the hearing and whether they wish to be legally represented. A section 18 application must be heard within five days of the application form being lodged with the court (excluding weekend and court holidays). Once the section 18 application has been lodged, the patient can continue to be detained until the order has been made or the case dismissed by the court.

The significance of section 18 orders and human rights

1.11 In 1997-1998, there were 4333 3-day detentions under sections 24 and 25. In the same year there were 2505 28-day section 26 detentions and 1055 6-month section 18 applications were granted. Far fewer patients are the subjects of appeals, either to the Commission or to the courts. In 1997-1998 the Commission reviewed 537 cases of detention, although no patients were discharged³. In the same year there were 30 appeals against section 30 renewals of a six-month detention⁴.

1.12 In all cases of compulsory detention there is a tension between the need to treat and protect the individual (and, in some cases, society) and the need to uphold the patient's right to their liberty. As these figures show, section 18 orders concern only a minority of the patients

¹ Mental Health (Detention)(Scotland) Act 1991.

² Act of Sederunt (Mental Health Rules) 1996.

³ Source: MWC Annual Report 1997-1998.

⁴ Source: Central Legal Office.

who are detained under the Act. However, they are an important minority as they can potentially spend months and sometimes years in hospital. The gravity of the loss of liberty means that the tension between these conflicting rights is at its greatest when a section 18 application is made.

1.13 The Human Rights Act 1999 came into force on 2 October 2000. For the first time, this means that a person may challenge in the courts the action of a public authority on the grounds that it has contravened that person's rights under the Act. Although the research was not commissioned specifically to look at this aspect of section 18 detentions, it does widen the context within which the section 18 process must be analysed.

The Aims of the Research

1.14 Although the information in the preceding paragraph shows how many orders are granted under the relevant sections mentioned above, there is very little information available beyond these bare numbers to explain how section 18 and the corresponding Sheriff Court Rules operate in the civil courts. Also, very little is known about appeals. This research was commissioned to try and fill in these gaps and in particular to provide the Millan Committee with information about the court process, which comes within its remit.

1.15 The specific aims of the research were to:

- collect and analyse information on the characteristics of cases dealt with in the sheriff court, including case and patient characteristics, case trajectory, outcome and timescale;
- describe and evaluate the operation and impact of the Act in a sample of Scottish courts;
- evaluate the extent to which the Act and associated legislation and procedures protect the interests of patients through the use of curators ad litem, independent medical or other evidence and appeals;
- assess the extent to which patients and relatives avail themselves of their rights, including the right to appear in appropriate cases and the right to appeal in respect of various sections of the Act and to consider what barriers there might be to uptake of rights;
- collect information on the extent to which patients are represented, by whom and whether in receipt of Legal Aid and to outline barriers to uptake and exercise of rights;
- identify the implications for people with different types of conditions, for example people with learning disabilities;
- evaluate the extent to which the Act operates in accordance with the requirements of a modern legislative framework, for example, to assess the extent to which it is independent, effective and appropriate.

The report

1.16 The report sets out the findings and conclusions of the research as follows:

Chapter 2 describes the research methods used in the research and why they were used. It highlights the problems encountered in using these methods and the measures taken to deal with them.

Chapter 3 presents the findings from an analysis of the database held by the MWC on all section 18 orders granted by the court. It also includes data about renewals and discharged orders.

Chapter 4 presents the findings of a national survey of local authority MHOs conducted between October 1999 and January 2000.

Chapter 5 presents the findings of case studies carried out in 3 courts across the country.

Chapter 6 is an analysis of the findings from Chapters 3 to 5 and incorporates interviews conducted with patients, support groups, psychiatrists, MHOs, solicitors, sheriffs and clerks across the country.

Chapter 7 is a concluding chapter and presents suggestions, based on the research findings for future policy and reform of the law and court procedures.

CHAPTER 2 THE RESEARCH METHODOLOGY

Introduction

2.1 A primary reason for commissioning this research was the lack of basic numerical information about the court process. Although the Scottish Court Service records the number of orders granted under Part V of the Mental Health (Scotland) Act, this is not broken down to show the types of order granted. The MWC maintains records including court papers on all patients detained under section 18. Key information about the court process from each case is stored on a database and updated by Commission staff. The Commission also publishes the number of orders granted each year under the Act in its Annual Report.

2.2 As the information available at the beginning of this research was very limited, consisting only of the number of orders granted each year, the researchers' primary task was to devise a way of obtaining the data that would enable them adequately to describe the court process. Their second task was to obtain the data that would allow them to evaluate the process.

2.3 The following research methods were used:

- An analysis of the MWC's database
- A survey of local authority mental health officers
- An analysis of court records in three courts
- Interviews with patients, support groups, MHOs, solicitors, psychiatrists, sheriffs and sheriff clerks.

In addition, data were provided from the Scottish Legal Aid Board database on legal aid payments made for mental health applications.

2.4 Different research methods were used in an attempt to capture as much national information as possible whilst also providing a more in-depth assessment of the operation of the Act.

The Mental Welfare Commission database

2.5 Individuals are given an identity number on the MWC database which allowed the researchers to have access to anonymised information.

2.6 Data were collected on all section 18 orders granted in one year, 1 April 1998 to 31 March 1999⁵. (One year was chosen to keep the research task manageable.) These were broken down by age of patient, region and/or health board, type of disorder and reason for the application. The Commission also records renewed orders and discharged orders. Data were collected on all orders that were renewed under section 30 in the same year and on all orders

⁵ References throughout the rest of the report to 'this year' refer to the year 1 April 1998 to 31 March 1999.

discharged between 1 April 1998 and August 1999. The data were analysed using Excel and the SPSS statistics package.

The Mental Health Officer survey

2.7 The MWC data could not provide the study with the depth and range of information required about the court process. A source was required that could provide the research with data about, for example, the number of patients who were legally represented and how many patients attended court for their hearings. After discussion with policy clients and the Association of Directors of Social Work, MHOs were identified as being the best source of this additional information.⁶

2.8 A questionnaire was sent to the MHOs who had dealt with section 18 cases in this year. MHOs were asked to provide the following information about each case:

- Patient's sex, ethnic group, ability to communicate, understanding of the order
- Length of time known to social work and history of previous orders
- Nearest relative's involvement
- Legal Aid
- Attendance at court and reason for patient's non-attendance
- Representation
- Evidence and contested cases
- Appeals

2.9 To reduce the burden on individual MHOs a sample of 739 out of a total number of 1055 orders was taken. Questionnaires for these were sent out towards the end of October 1999 and responses accepted up until the first week of January 2000. In total 522 questionnaires were returned, a response rate of 71 per cent, and these were analysed using SPSS.

Case studies

2.10 The MWC and MHO survey data provided the research with a national picture of the court process. The research was also asked to provide an in-depth picture of how the Act is applied in different parts of the country. Three courts were selected which were known to have dealt with a significant number of cases in this year and to service three very different areas. Two were located in urban areas, the other served a mostly rural population. Access to the three courts was arranged through formal access agreements between the Central Research Unit and the Sheriffs Principal.⁷

⁶ See Appendix 2 for detailed description and background to MHO survey.

⁷ See Appendix 2 for more details about method.

2.11 The data for this part of the research were collected from the following sources:

- The prescribed court forms
- Standard letters and forms relating to the Sheriff Court Rules
- Notes on continuations
- Separate MHO reports (where they were filed)

Interviews

2.12 The final research method used was interviews with people involved in the section 18 process. Interviews were conducted in all three case study areas and across the country. Interviews were carried out with the following:

6 psychiatrists
1 pharmacist
1 charge nurse
1 medical records officer
8 solicitors
5 MHOs
10 patients
1 relative
11 support agencies
3 sheriffs (one each from the case study courts)
3 sheriff clerks (one each from the case study courts)

2.13 Interviewees were identified because they represented a prominent organisation, because they were members of the project's Research Advisory Group, or because they had been suggested by members of this group.⁸

2.14 Interviewees were asked to talk about how the court process appeared to work in their local area, what problems they perceived in the system and generally about their experiences of the mental health process.

Summary

2.15 The study attempted, as far as was possible, to collect data by different methods and from different sources in order to provide both a national picture and a picture of how the legal process differs across the country. In the following chapters, the results of these different methods are presented and analysed.

⁸ Whose members are professionals and service users with experience of mental health issues.

CHAPTER 3 MENTAL WELFARE COMMISSION DATA

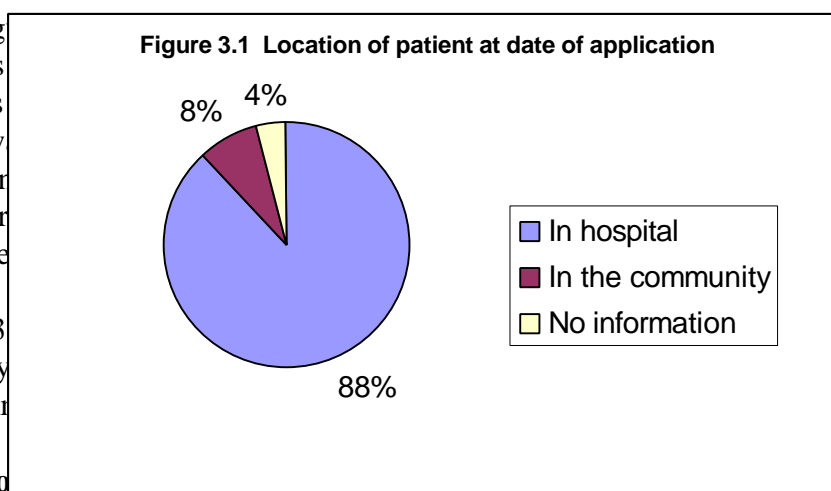
Introduction

3.1 The Mental Welfare Commission (MWC) keeps a file on all patients detained under the Act, including those detained under section 18. Their database was used to provide some basic information about the number of orders granted in this year.

1.1 Orders granted

3.2 In this year 1055 section 18 orders were granted. Of these, 1047 were made on separate patients; the remaining 8 cases represented people who were detained for a second time during this period.

3.3 As Fig the order was the order was community as information w This shows an setting, this pr the start of the



hospital when spital from the ent of cases no r was granted. thin a hospital ention prior to

3.4 Only 3 were made by relative was kn

52 applications le) the nearest

1.2

1.3 Ages of

3.5 The ages of the people being detained ranged between 15 and 96 years. As Table 3.1 illustrates, 67 per cent of patients detained under section 18 were aged below 50 years and 48 per cent were aged between 20 and 39 years.

1.3.1

1.3.2 Table 3.1 Age bands

Age Bands (years)	Number	Percentage (N = 1047)
15-19	27	3
20-29	209	20
30-39	294	28
40-49	171	16
50-59	102	10
60-69	94	9
70-79	85	8
80-89	53	5
90-99	11	1
Missing data	1	*
TOTAL	1047	100

*Under 1%

Young people

3.6 At the date of their detention, 4 patients were aged under sixteen, and 8 were aged sixteen.

1.3.3

1.4 Reason for using detention

3.7 Applications to the sheriff court for section 18 detentions identify the type of mental disorder from which the patient is suffering (see table 3.2). Ninety-eight per cent of patients were said to have a mental illness, whilst only 5 were said to have a learning disability. One per cent of patients (11) were said to have both a mental illness and a learning disability.

Table 3.2 Type of mental disorder recorded by doctors recommending detention

1.4.1 Type of disorder	Psychiatrist		GP	
	Number	% (N = 1055)	Number	% (N = 1055)
1.4.2 Mental illness	1032	98	1034	98
Learning disability	5	*	4	*
Both	11	1	12	1
Missing data	7	1	5	1
TOTAL	1055	100	1055	100

*Under 1%

3.8 As well as identifying the type of mental disorder the patient suffers from, doctors have to describe the form this disorder takes from a list of 4 options printed on the form they submit to the court. Table 3.3 outlines the reasons given by the psychiatrist and the GP. In almost 100 per cent of cases where the patient was said to have a mental disorder, this was described as:

‘a mental illness of a nature and degree which makes it appropriate for him/her to receive medical treatment in a hospital’.

3.9 In only a few cases was the patient's mental disorder described as:

'a mental illness which is a persistent one manifested only by abnormally aggressive or seriously irresponsible conduct and which makes it appropriate for him/her to receive in a hospital medical treatment which is likely to alleviate or prevent a deterioration of his/her condition'.

1.4.3 Table 3.3 Forms of mental disorder that led GP/psychiatrist to believe person should be detained

1.4.4 Reason for detention	Psychiatrist		GP	
	Number	% (N = 1055)	Number	% (N = 1055)
1.4.5 Appropriate to receive medical treatment in hospital	1044	99	1038	98
Persistent aggressive or seriously irresponsible behaviour resulting in need for treatment	2	*	3	*
Missing data	9	1	14	1
TOTAL	1055	100	1055	100**

*Under 1%

**Percentages do not add up to 100 due to rounding

3.10 Among the learning disability patients, 2 were said to have a learning disability that made it appropriate for them to receive medical treatment in hospital. Two/three patients (the doctors disagreed in one case) were said to have a mental impairment that made it appropriate for them to receive medical treatment that was likely to alleviate or prevent a deterioration of their condition.

3.11 Although the majority of patients are detained due to mental illness, the age range of people being detained according to mental disorder type does show a variation between those with mental illness and those with a learning disability. For example, as Table 3.4 illustrates, the small number of people recorded by psychiatrists as having learning disabilities were all within the age bands 20 to 39 years (5 cases). The patients who were said to have both a mental illness and a learning disability were more widely spread across the 30-59 age bands (8 cases). Patients who were said to have only a mental illness, while predominantly in the age bands 20 to 49 years, were spread throughout the age spectrum. As Table 3.2 showed, psychiatrists and GPs differed over the category of mental disorder suffered by 4 patients.

Table 3.4 Type of disorder recorded by age band of person being detained

Age band (years)	Type of disorder					
	Mental illness	%	Learning disability	%	Both	%
15-19	25	2			2	20
20-29	204	20	2	40		
30-39	287	28	3	60	3	30
40-49	169	17			2	20
50-59	99	10			3	30
60-69	93	9				
70-79	83	8				
80-89	53	5				
90-99	11	1				
Missing data	23					
TOTAL	1024	100	5	100	10	100

Nearest relatives

3.12 The nearest relative was known in 95 per cent of cases and was informed of the application in 93 per cent of cases. In 2 per cent of cases the local authority was unable to ascertain who the nearest relative was; in 2 per cent of cases no nearest relative was thought to be available.

1.5

1.6 Section 18 detentions by local authority

3.13 Table 3.5 shows that in this year, Glasgow had the greatest number of applications with 154 (14%), followed by Edinburgh with 128 applications (12%). The remaining local authority areas made use of this measure in significantly fewer numbers. Fife council made 88 applications (8%) and Aberdeen city council made 61 applications (6%). The wide variation between the number of applications in each local authority may have been due to population differences between each area. However, larger local authorities may be more confident about pursuing this option and have specialist resources within their area.

Table 3.5 Applications by local authority

Local authority	Number of orders	% (N = 1047)
Aberdeen	61	6
Aberdeenshire	11	1
Angus	16	2
Argyll & Bute	29	3
Clackmannanshire	5	1
Dumfries & Galloway	42	4
Dundee	55	5
East Ayrshire	14	1
East Dunbartonshire	9	1
East Lothian	13	1
East Renfrewshire	16	2
Edinburgh	128	12
Falkirk	23	2
Fife	88	8
Glasgow	154	15
Highland	44	4
Inverclyde	30	3
Midlothian	20	2
Moray	14	1
North Ayrshire	24	2
North Lanarkshire	37	4
Perth & Kinross	31	3
Renfrewshire	36	3
Scottish Borders	25	2
South Ayrshire	23	2
South Lanarkshire	37	4
Stirling	8	1
West Dunbartonshire	19	2
West Lothian	35	3
Missing data	8	1
TOTAL	*1047	100

*8 cases had no LA information, 3 of which were the section 18 orders applied for by a relative.

Number of section 18 orders per 100,000 of population

3.14 Figure 3.2 (previous page) shows the number of section 18 orders in each local authority per 100,000 population. Dundee had the highest number, followed by Inverclyde, Argyll & Bute, Aberdeen and Dumfries & Galloway. Edinburgh had the sixth highest number of orders and Glasgow, which had the highest number of orders overall, came joint seventh with Fife and Midlothian.

1.7

1.8 Renewals

3.15 2005 section 18 orders were renewed between April 1998 and the end of March 1999. Of this number, 457 involved more than one renewal application for the same patient, so in all, 1548 patients had their section 18 detentions renewed during this period. Of these patients 490 (32%) started their detention during the monitoring year, while the remaining 1058 started their detention prior to April 1998.

3.16 The following data include all the 1548 patients whose orders were renewed during this year.

3.17 The patients whose orders were renewed during this period had, in some cases, been subject to a section 18 detention for many years. Some patients had been detained under section 18 since the 1970s.

- One per cent (16) of patients were admitted to hospital in the 1970s under the equivalent of a section 18 detention and were still detained under section 18 at the time of the data collection exercise.
- 6 per cent of patients (89) began their detention during the 1980s
- 20 per cent of patients (317) began their detention during 1990 to 1995
- 32 per cent (494) began their detention during 1996 or 1997
- 9 per cent (142) started their detention between January and March 1998.

1.9 Health Boards involved in renewal

3.18 On renewals of application of section 18 detentions, no information relating to the local authority or the type of doctor was recorded in the MWC data. However, information is available to show how renewals were distributed across Health Boards.

3.19 As Table 3.6 illustrates, the greatest number of renewals took place within Lothian with 331 cases (16%). Following this was Greater Glasgow with 275 cases (14%) and then Argyll & Clyde with 205 cases (10%) and Tayside with 203 cases (10%). There was a slight variation between which Health Board had the highest incidence of renewal as compared with new applications. Greater Glasgow had the largest number of new applications, followed by Lothian and then Argyll & Clyde. Lothian, however, was the largest user of renewals, followed by Greater Glasgow.

1.9.1 Table 3.6 Health Boards undertaking renewals under section 18 detention

Health Board	Number of renewals	Number of hospitals in Health Board
Lothian	331	17
Greater Glasgow	275	14
Argyll & Clyde	205	10
Tayside	203	10
Lanarkshire	165	8
Fife	162	8
Grampian	156	8
State Hospital (Carstairs)	124	6
Ayrshire & Arran	118	6
Forth Valley	105	5
Highland	73	4
Dumfries & Galloway	58	3
Borders	30	2
Orkney	-	-
Shetland	-	-
Western Isles	-	-
TOTAL	2005	*101

*Percentages do not add up to 100 due to rounding

3.20 Some hospitals renewed a higher number of section 18 detentions than others. The Royal Edinburgh in Lothian renewed the highest number of orders - 235, which represented 12 per cent of all renewals. This was followed by the State Hospital and Royal Cornhill Hospital in Grampian, both of which had 124 renewals (6% of all renewals). These figures were significantly higher than those for other hospitals, which may reflect their status as specialist hospitals for long-term patients.

1.10 Reason for renewal

3.21 As with new applications, most patients whose orders were renewed were said to have a mental illness (95% or 1005 cases). 3 per cent (32 cases) had a learning disability and 2 per cent (21 cases) had both a mental illness and a learning disability.

3.22 In 99 per cent (1047) of mental illness renewals, the RMO stated that the patient's mental illness required hospital treatment. In the remaining 1 per cent (11) of cases the RMO stated that the patient's mental illness showed itself only by '*abnormally aggressive or seriously irresponsible conduct*' which required hospital treatment.

3.23 Finally, the RMO has to state whether the renewal is necessary for the patient's safety and/or the protection of other people. 56 per cent (592 cases) of cases were renewed for the patient's safety, 1 per cent (11 cases) for the protection of others and the remaining 43 per cent (455 cases) for both the patient's safety and for the protection of others.

1.11

Discharge of orders

3.24 Of the 1055 applications granted during the monitoring year, 32 per cent (339 cases) were discharged during the same period. Table 3.7 shows that 35 per cent were discharged after exactly 6 months and 61 per cent were discharged in 5 months or less. The average length of detention was 4 months.

Table 3.7 Duration of section 18 detentions which began and ended this year

Duration	Number	% (N = 339)
Less than 1 month	2	1
1 month	86	25
2 months	44	13
3 months	36	11
4-5 months	37	11
6 months	117	35
7-11 months	14	3
12 months	3	1
TOTAL	339	100

3.25 To obtain a longer-term picture of patterns of discharged orders, data were collected on all discharged section 18 detentions that had begun during the monitoring year and ended by August 1999, i.e. a total of 539 cases. A sample of 397 discharged section 18 detentions that had started before April 1998 were also analysed. In total, therefore, data were collected on 936 cases that were discharged after 1 April 1998.

3.26 Table 3.8 shows that over half of the orders (52%) lasted six months or less. In addition, 19 per cent lasted between 7 months and a year and a further 13 per cent lasted between 13 months and two years. Only 16 per cent of cases lasted longer than two years and resulted in a discharge during the period April 1998 to August 1999.

**1.11.1 Table 3.8 Duration of section 18 detentions discharged between
1.11.2 April 1998 and August 1999**

Duration	Number of cases	% (N = 936)
Less than 1 month	9	1
1 month	85	9
2 months	51	5
3 months	43	5
4 months	20	2
5 months	56	6
6 months	221	24
7-12 months	173	19
13-18 months	70	7
19-24 months	59	6
25-36 months	46	5
37-48 months	35	4
48-60 months	20	2
61-120 months	35	4
120 months and over	13	1
TOTAL	936	100

3.27 485 detentions lasted for six months or less; 221 of them (46%) lasted exactly six months while 18 per cent lasted only a month (85 cases). At the other extreme, although only a minority of section 18 detentions lasted over two years in duration (16%), the average duration of detentions that lasted more than two years was around 63 months (over 5 years). Within this group, the duration of detentions ranged from 25 months (just over two years) to 284 months (almost 24 years). So, although the greatest number of detentions lasted six months or less, in a significant minority of cases the patient was subject to this form of detention for periods of years, in some cases ten years or more.

1.12 Reasons for discharge

3.28 Table 3.9 shows that in 61 per cent of cases the RMO discharged the order and in 31 per cent of cases the section 18 expired without renewal.

1.12.1 Table 3.9 Reason for discharge of section 18 order

Reason for discharge	Number of cases	% (N = 936)
by order of RMO	563	60
expired without renewal	290	31
patient died	48	5
other reason	18	2
transferred outside Scotland	4	*
discharged to court	2	*
absent without leave	1	*
unknown reason	10	1
TOTAL	936	**99

*Less than 1%

**Percentages do not add up to 100 due to rounding

3.29 Table 3.10 shows the location of patients at the time of the discharge of section 18 detention. As these data illustrate, the majority of patients were on Leave of Absence when the order was discharged (57%). In a further 25 per cent of cases the patient remained in hospital informally and in only 13 per cent of cases did the patient leave hospital following the discharge.

1.12.2 Table 3.10 Patient's location at time of discharge of section 18 detention

Location at time of discharge	Number of cases	% (N = 936)
on leave of absence, discharged in absence	531	57
remained in hospital informally	230	25
left hospital	122	13
Missing data	53	6
TOTAL	936	*101

*Percentages do not add up to 100 due to rounding

3.30 Table 3.11 shows how the patient's location at the date of the discharge interacts with the reason for the discharge. In 63 per cent of Leave of Absence cases, the order was discharged by the RMO. In 35 per cent of Leave of Absence cases, the order expired and was not renewed.

3.31 Of the patients who remained in hospital at the time of the discharge, 63 per cent had had their order discharged by the RMO and a further 36 per cent of orders expired and were not renewed. Of those who left hospital at the time of the order being discharged, 65 per cent had been discharged on the order of the RMO and 15 per cent of orders had expired without renewal. In 14 per cent of these cases the patient died.

1.12.3 Table 3.11 Reasons for discharge and the patient's location at time of discharge

Reason for discharge	Patient's location at time of discharge					
	On LOA	% (N = 531)	Remained in hospital	% (N = 230)	Left hospital	% (N = 122)
discharged by RMO	334	63	144	63	80	65
expired without renewal	184	35	83	36	18	15
patient died	2	*	0	0	17	14
other reason	10	2	3	1	2	2
transferred outside Scotland	0	0	0	0	3	2
discharged to court	0	0	0	0	2	2
TOTAL*	530	100	230	100	122	100

*Data missing for 49 cases

3.32 The activities of patients during and after the use of a section 18 detention show how this measure is used in a flexible way in practice. In many cases, doctors appear to use section 18 to allow a patient to leave the hospital, while keeping some control over them in the community. Conversely, there are people who come to the end of their period of detention under section 18 who continue to remain within a hospital setting informally. Section 18 detention appears to be only one way of offering treatment within a hospital setting to those that are thought to be a risk to themselves or others and who require medical treatment.

1.13 Summary

3.33 It seems from the findings reported here that the use of section 18 orders is predominantly intended as a short-term measure to detain a patient within hospital for a longer period than the section 26 order allows. The figures also show that those who are subject to this order tend both to experience mental illness, rather than learning disabilities, and are predominantly under 50 years of age.

3.34 As with other parts of the Mental Health legislation, the regional variation shows that highly populated areas such as Glasgow, Edinburgh and Fife use section 18 orders in higher numbers than the smaller and more rural areas of Scotland. This may simply reflect the size of populations within different areas. However, further investigation is required to assess whether there are other reasons for this variation in use and to explain why some areas rarely or never use section 18 orders.

CHAPTER 4

MENTAL HEALTH OFFICER QUESTIONNAIRE

THE NATIONAL PICTURE

4.1 Analysis of the questionnaires was conducted using the SPSS statistics package. The data that are presented below must be read with the caveat that MHOs might not always have been able to provide the information requested. For example, there may have been a problem defining a patient's ethnic group or checking a patient's history. For information about court process, we relied upon MHOs checking their files for a record of, for example, solicitors' names. Some may have relied on their memory of the court hearing and some may have relied on their memory. Whilst this means there may well be some limitations of memory or recording on the part of MHOs, they were the best source for the data required, as they play a pivotal role in section 18 detention proceedings. They fill in the application forms and are the most likely person to attend court (as the results bear out).

Patient personal characteristics

4.2 MHOs were asked to indicate the patient's sex, ethnic group and first language as this information had not been recorded by the MWC on their computer database.

Sex

4.3 The MWC provided the researchers with data that allowed estimates to be made of how many men and women were detained under section 18. This ratio was roughly comparable to the ratio presented in the questionnaire responses, about 52 per cent men to about 48 per cent women.

Ethnic group

4.4 The majority of patients were reported to be white (98%). The remaining 9 patients came from a range of other ethnic groups appearing.

Patient's first language

4.5 English was reported to be the first language for 510 patients (97%). The first language of the other 10 patients varied, but European languages outnumbered any others. Sign language was the first language for 2 patients.

Able to communicate wishes/feelings

4.6 MHOs were asked if their patient could communicate their wishes and feelings. The majority (76%) of patients were thought to be able to do so although there were also 87 'Don't know' responses (18%).

Understanding of the order

4.7 MHOs were also asked if, in their opinion, their patients understood that they were or had been subject to the section 18 detention. 84 per cent said yes; 11 per cent said no. This is a social work, not a legal or medical assessment, and so cannot be taken to show that the patient is legally incapax. However, the responses to this and the question about wishes and feelings raise issues about the patient's ability to make decisions about such matters as whether or not they wish to be legally represented and their ability to give instructions to a solicitor.

Patient's previous history

Number of months known to social work department because of mental health problems

4.8 Although MWC data show when the patient first became subject to an order, the researchers wanted to find out for how long a patient had been known to social work as a result of problems associated with their mental health. This was a more informal measure, which would give an indication of how long patients had been 'in the system'. The question was asked in such a way as to distinguish social work involvement triggered by mental health issues from that triggered by other issues such as housing or child protection. In many cases, however, it was difficult to disentangle a patient's mental health problems from other areas of their life that brought them into contact with social work departments. However, with this caveat, the results remain of interest.

4.9 Over a third of the patients (35%) had been known to social work because of their mental health for 18 months or less and 10 per cent had been known for 20 years or more. The average length of time patients had been known to social work was 57 months (see table 4.1).

Table 4.1 Length of time known to social work

Number of months known to social work	Number of cases	% of total (N = 522)
6 months or less	98	19
7 months - 12 months	53	10
13 months - 18 months	31	6
19 months - 24 months	47	9
25 months - 36 months	22	4
37 months - 48 months	45	9
49 months - 60 months	36	7
61 months - 72 months	21	4
73 months - 84 months	11	2
85 months - 96 months	14	3
97 months - 108 months	12	2
109 months - 120 months	27	5
121 months - 180 months	21	4
181 months - 240 months	21	4
241 months - 360 months	8	2
361 months - 480 months	1	0
Missing data	54	10
TOTAL	522	100*

*Percentages do not add up to 100% due to rounding

Had the patient been subject to previous orders under the Mental Health (Scotland) Act?

4.10 Again, this question was asked to obtain some idea of the patient's history. Results were split almost 50/50 between those patients who had been subject to previous orders and those who had not. These results are surprising, given that the proportion with a previous order is significantly lower than findings from in other studies would suggest. The analysis of MWC data in stage 1 of this research shows that 88 per cent of the patients detained under section 18 orders were already in hospital. We know from other research⁹ that in 1997-1998, 85 per cent of people detained under section 18 had first been detained under sections 24/25 and 26 of the Act. It is possible that MHOs took 'previous orders' to mean orders before the most recent period of detention. They would therefore not count the section 24/25 or section 26 order that preceded this section 18 order.

4.11 In some cases, MHOs reported that the patients' complete history was not available from their files. The data should be read with this caveat in mind.

Previous orders

4.12 MHOs were then asked to identify the type of orders made. 5 orders were identified in the questionnaire:

- i. Community Care Orders
- ii. Guardianship
- iii. section 24 emergency detention orders
- iv. section 26 detention orders
- v. section 18 detention orders

4.13 As shown in Table 4.2 the first 2 orders had been used the least. Only 4 patients had been the subjects of Community care orders and only one patient had been the subject of a Guardianship. 39 per cent of patients had been subject to section 24 orders, 43 per cent had been subject to section 26 orders and 35 per cent to section 18 orders.

Table 4.2 Previous orders

Orders	Number	Missing data	% (N = 522)
Community Care	4	0	1
Guardianship	1	0	*
s 24	202	14	39
s 26	223	3	43
s 18	181	3	35

*Less than 1%

Other orders

4.14 The questionnaires picked up 4 patients who had been subject to orders under the Criminal Procedure (Scotland) Act. Other respondents indicated that their patients had had a

⁹ Keenan, T. *The Predominant Use of Emergency Involuntary Admission under Section 24 of the Mental Health (Scotland) Act 1984, 1999* (unpublished).

history of up to 40 admissions made up of those of an informal as well as a formal nature. These comments confirm that the mental health history of a number of patients is characterised by a cycle of periods of voluntary and involuntary admissions and periods of time in the community.

Involvement of nearest relative

Was the nearest relative involved in the application?

4.15 MHOs were asked whether the patient's nearest relative was involved in the application and to say what form that involvement took. Under section 19(5)(b) an MHO is obliged to inform the nearest relative of the proposed application.

4.16 We knew from our Stage 1 analysis of data held by the MWC that the nearest relative had been informed in 93 per cent of cases. We also know that in 16 cases (2%) it was not possible to ascertain the nearest relative's identity and in 18 cases (2%) no nearest relative was thought to exist. In 4 cases the local authority or another person had been authorised by the court under section 56 to be the acting nearest relative. In 3 cases the nearest relative had made the application. This question was designed to find out what active part other relatives played in the section 18 application.

4.17 In the current study, in 81 per cent of cases the nearest relative was said to have been involved (Table 4.3). In some cases, 'involvement' was interpreted as the MHO informing the relative of the application. For our purposes this was not regarded as 'involvement'. The MHO was obliged to inform the relative. We were interested in finding out if the relative responded and how.

How was the nearest relative involved?

4.18 MHOs were given a range of options to tick. By far the most common form of involvement was discussing the application with the MHO (79%), followed by accompanying the patient to meetings (13%). Only 6 per cent of nearest relatives attended the court hearing and in only 2 cases (under 1% of the sample) had the nearest relative made the application. In many cases 2 or more boxes were ticked.

Table 4.3 Nearest relative's involvement

	Yes	Missing data	% of total (N = 522)
Made application	2	9	*
Discussed application with MHO	410	9	79
Accompanied patient to meetings	65	9	13
Attended court	29	9	6
Other Involvement	20	2	4

*Less than 1%

4.19 'Other involvement' included

- making representations to the sheriff in court
- visiting the patient in hospital and attending carers' groups
- representing the patient (see below)
- liaising with the patient's child's social worker
- attending meetings with social work and giving continuing support and care
- Contesting the section 18 application (2 cases)

Legal Aid

4.20 Legal Aid in the form of Assistance by Way of Representation (ABWOR) is available for Mental Health Act applications, but is means-tested¹⁰. We wanted to find out from MHOs whether their patients had been granted Legal Aid and if not, why not.

4.21 After the questionnaires had been sent out, national data on legal aid payments was received from the Scottish Legal Aid Board. This shows that in the 1998-1999 financial year there were approximately 650 intimations made by solicitors for legal aid to represent patients in section 18 applications. A further 51 intimations were made which did not indicate the order that was being sought in court. This figure may therefore include further section 18 applications. Taking into account the fact that the questionnaire responses cover only half the section 18 orders granted in that year, this is still a far higher number of legal aid intimations than the number indicated in these figures. See page 34 for further comment on the relevance of these data to the figures for legal representation.

4.22 However, the MHO data remain useful for the information they give on why patients did not apply for legal aid when they could have done so. It should be borne in mind that the data rely on the MHOs knowing whether their patients had legal aid or not.

4.23 27 per cent of patients were reported to be in receipt of legal aid, while 57 per cent were not and a 'Don't know' response was received for 13 per cent of patients.

Why didn't the patient have legal aid?

4.24 MHOs were asked, 'If the patient was eligible for legal aid but did not apply for it, do you know why?' The answers again relied on MHOs having some knowledge of their patients' legal aid status. Out of the 202 patients who were eligible for legal aid, MHOs could say why they had not applied for it in 84 per cent of cases.

Reasons for not applying for legal aid

4.25 The main reasons given were

- did not wish to apply for legal aid (7% of patients)
- did not contest the application (67% of patients)
- did not want legal representation (11% of patients)

¹⁰ This was changed in April 2000.

- the patient represented him/herself (4% of patients)

In addition 13 patients were said not to be eligible for legal aid (6% of patients)

Table 4.4 Reasons for not applying for legal aid

Reason	Frequency	% N = 202
Not eligible	13	6
Did not wish to apply for legal aid	14	7
Did not contest the application	136	67
Patient did not want legal representation	22	11
Patient represented him/herself	9	4
Other reason	43	21
TOTAL = number of responses	*237	**

*Multiple responses given for some patients

**Percentages do not add up to 100 due to multiple responses

4.26 The biggest group by far was made up of those patients who did not wish to contest the application (67% of patients). The ambivalence of some patients' feelings about contesting was shown in the comments made by MHOs on the questionnaires:

- 'Did not want to contest - felt she would lose. Was against the imposition of the order.'
- 'Did not want to contest - felt he would lose anyway.'
- 'Patient indicated his opposition but did not wish legal representation nor to attend court.'
- 'Generally just did not feel it was going to be worth her while and worth the effort to oppose the section 18.'
- 'Did not wish to contest in court, although disagreed with section 18.'
- 'Saw section 18 as safety net and didn't want to contest.'
- 'Ambivalent about contesting and declined opportunity to speak to a solicitor.'
- 'In discussions with relative, need for section 18 explained, accepted, therefore they did not pursue legal aid.'

Other reasons for not applying for legal aid

4.27 In 10 cases patients were said to be unable properly to understand the situation they were in or to instruct a solicitor because of their illness. In 4 cases the patient was ineligible for legal aid and was said to have refused to pay for legal representation out of their own funds

Sheriff courts

4.28 31 out of the 49 sheriff courts in Scotland heard section 18 detention applications. . Between them, Glasgow and Edinburgh heard more than a quarter (26%) of all the section 18 cases.

Patients' Attendance at court

4.29 MHOs were asked if they or a colleague had attended court for the section 18 hearing. The majority (87%) had done so. MHOs were also asked if their patients had attended court.

The figure for attendance here was much lower. Only 28 per cent of patients were reported to have attended court.

Why didn't the patient attend the hearing?

4.30 MHOs were given a range of possible explanations for the patient's non-attendance at court and the option to give other reasons for their non-attendance. The reasons given were:

- Unable to attend as a direct result of mental disorder
- Ill-health
- No transport
- Too far to travel
- No one available to accompany patient
- Did not wish to attend
- Application accompanied by medical opinion that it was not in patient's interests to be present during the proceedings

4.31 The largest group (81%) comprised those patients who it was said did not wish to attend court, followed by the 20 per cent who were said to have been unable to attend due to their mental disorder. In 9 per cent of cases where the patient did not attend, MHOs said that ill-health had kept the patients away. 4per cent were reported not to have attended because the doctors in the case had stated that it would not be in the interests of the patient's health to attend. In 2 cases the distance to court was said to be too far and in One case there was noone to accompany the patient to court. In 3 per cent of cases other reasons were cited. In no cases was non-attendance due to lack of transport.

Table 4.5 Reason for the patients' non-attendance

Reason	Frequency	% of patients who did not attend court (N = 360)
Did not wish to attend	291	81
Mental disorder	73	20
Ill-health	33	9
Medical opinion that patient should not attend	16	4
Other reasons	16	4
Too far to travel	2	1
No one available to accompany patient	1	*
TOTAL number of responses	432	**

*Less than 1%

**Percentages do not add up to 100 because of multiple responses

Other reasons for non-attendance

4.32 Other reasons given for non-attendance included:

- Patient was detained in the State Hospital.
- 'Did not feel that he could change anything by doing so - powerless.'

- ‘Felt there was no point.’
- ‘Client not aware or motivated enough to attend.’
- ‘Very intimidated by court setting, saw it as doing something wrong.’
- ‘Dismissive of the application and did not want to be involved.’
- ‘Felt it was pointless to oppose detention but not happy about it.’
- ‘Didn't want to appear in court.’

Patients' Representation in court

4.33 MHOs were asked whether their clients were represented in court and, if so, by whom. 203 (39%) clients did have representation and nearly all of them (200) were represented by a solicitor (Table 4.6).

Table 4.6 Who provided representation?

	Frequency	% of those represented (N = 203)
Solicitor	200	99
Other person	3	1
Not applicable (client unrepresented)	307	
Missing data	12	
TOTAL	522	100

4.34 The 3 other people who represented patients were family members, including, in one case, the patient's husband. 9 patients were said not to have applied for legal aid because they wanted to represent themselves. In fact 1 of these patients did have legal representation to begin with but then represented themselves. Another was represented by a curator ad litem appointed by the court.

4.35 To obtain a picture of how widespread mental health practice is amongst lawyers, MHOs were asked if they knew the firm that had represented their patients. In 78 cases (39%) this information was not given. It was clear that in certain areas, maybe only one or 2 firms were taking on most of the work. The most striking examples were in Borders, Falkirk and Glasgow.

4.36 The data received from the Scottish Legal Aid Board (see page 27) would appear to show that the number of patients seeking legal advice was considerably greater than the number who were, (according to MHOs) eventually represented by a solicitor in court. In total, 650 applications for legal aid under section 18 were made in the financial year. The questionnaire focused on legal representation in court rather than general legal advice because MHOs would not necessarily have comprehensive information about the legal advice sought and taken by their patients.

How did the patient obtain legal representation?

4.37 The questionnaire asked whether patients chose their own solicitors or whether they were appointed by the court. The Act of Sederunt (Summary Applications, Statutory Application and Appeals etc. Rules) 1999 prescribes 2 situations in which the court may appoint a solicitor to act as a patient's legal representative in section 18 applications. Under

Rule 3.8.5 the court may appoint a solicitor to act as the patient's curator ad litem. Under Rule 3.8.6 the court may appoint a solicitor to act for a patient where the patient has indicated a wish to be represented at the hearing but has not chosen their own solicitor. The role of a solicitor is very different from that of a curator ad litem. As Rule 3.8.6 makes clear, when a solicitor is appointed to act as a representative, the solicitor acts on the patient's instructions. When appointed as a curator ad litem, a solicitor acts in what they consider to be the patient's best interests.

4.38 Of the 200 patients who were legally represented, 119 (60%) were reported to have chosen their own solicitor (Table 4.7) and the court appointed a solicitor for 56 patients (28%) (Table 4.8).

Table 4.7 Did the patient choose their own solicitor?

	Frequency	% of those who were legally represented (N = 200)
Yes	119	60
No	79	40
Not applicable	310	
Missing data	14	
TOTAL	522	100

Table 4.8 Did the court appoint the patient's solicitor?

	Frequency	% of those who were legally represented (N = 200)
Yes	56	28
No	144	72
Not applicable	310	
Missing data	12	
TOTAL	522	100

Table 4.9 Did the court appoint a curator ad litem?

	Frequency	% of those who were legally represented (N = 200)
Yes	48	24
No	462	
Missing data	12	
TOTAL	522	

4.39 Of the 48 cases in which a curator ad litem was appointed, 22 of these came from the Borders.

4.40 According to the above Tables, 40 per cent (79) of those represented by a solicitor were said not to have chosen that solicitor. The court was said to have appointed 56 of them, 48 of them as curators ad litem. This leaves a further 23 solicitors whose appointment is unclear and 8 who were said to have been appointed by the court. As mentioned above, under Rule 3.8.6 of the Act of Sederunt 1999, the court can appoint a solicitor to act for a patient if the patient does not have representation and would like to be represented. This may explain some of these cases. It is also possible that the courts are exercising wider powers and

appointing solicitors to patients when they have indicated that they wish to be represented at the hearing but have failed to have a representative present with them.

4.41 We also know from comments on the questionnaires that 3 of these patients asked the MHO to choose a solicitor for them and 2 patients chose their solicitor from a list given to them either by the hospital or the MHO. In one case, the patient's family chose a solicitor for them. It is possible that this may explain some of the outstanding 23 cases.

Local authority representation

4.42 In 41 per cent of cases the local authority was said to have been represented in court. This is roughly the same as the number of patients who were represented.

Oral evidence

4.43 We wanted to know in how many cases oral evidence (as opposed to written reports) was heard and who was called to give this evidence. Oral evidence was taken to mean formal evidence, sworn on oath, rather than informal discussions between lawyers and patients and the sheriff. Before a hearing, a sheriff will have medical recommendations from a psychiatrist and a GP and from the MHO, written on court forms. As the case studies show, in some cases the doctors' recommendations are very short, maybe only 3 or 4 lines. In some courts, the sheriff will also have separate written reports from MHOs, although this practice seems to vary across local authorities.

4.44 In 50 per cent of cases oral evidence was given.

Who gave evidence?

4.45 MHOs were given a list of key people who might be called upon to give evidence. In many cases more than one person gave evidence. Table 4.10 sets out these findings.

Table 4.10 **Persons called to give evidence (all cases)**

	Frequency	% of cases in which evidence was heard (N = 263)	% of all cases (N = 522)
MHO	230	87	44
Patient	95	36	18
Psychiatrist	96	37	18
GP	70	27	13
Nearest relative	18	7	3
Other person	6	2	1
TOTAL = total number of witnesses giving evidence	515	*	*

*Percentages not given due to multiple responses

4.46 The MHO gave evidence in almost half the total number of cases (44%) - patients and psychiatrists in 18 per cent of all cases and GPs in 13 per cent. The nearest relative gave evidence in only 3 per cent of cases and other people were called in one per cent of cases (but we do not know who they were. The cases studies show the other types of people called to give evidence in these cases - primarily nursing staff).

Patients and nearest relatives

4.47 Patients attended court in 148 cases (28%) and gave evidence in 95 of those cases. Nearest relatives attended court in 29 cases (6%) and gave evidence in 18 of them.

MHOs

4.48 MHOs gave evidence in less than half of the cases they attended. Comments on some questionnaires indicated that the MHO had spoken to the sheriff in court but had not given evidence on oath. They therefore did not tick the box to say that they had given evidence, although they clearly played an informal role in the hearing. We do not know how often this happened, save where the MHO mentioned it on the questionnaire. It would seem unlikely that in the 56 per cent of cases in which the MHO attended but did not give evidence, they played no part in the proceedings.

Psychiatrists

4.49 The evidence of the psychiatrist in the case is crucial. Their evidence forms the basis of all section 18 applications. It would therefore appear to be difficult to contest a case successfully (on anything other than a legal technicality) without disputing the psychiatrist's assertion that the patient needs to be detained. The relatively low number of cases in which the psychiatrist was called (18%) would appear to bear this out.

GPs

4.50 GPs gave evidence in fewer cases than did psychiatrists. Interview data and the case studies points to GPs having, in many cases, a peripheral role to play in section 18 applications. Certainly, they are not called upon to expand on their written reports very often. This occurred in only 13 per cent of cases.

Other witnesses

4.51 In only 6 cases was another person called upon to give evidence. We do not have details about this although in 5 cases a second psychiatric opinion was asked for and the psychiatrist gave evidence.

Contesting the application

4.52 27 per cent of applications were contested, in all but two cases by the patient. As the Tables above show, contesting the case did not always involve calling key witnesses such as the psychiatrist. Neither did it always involve the patient giving evidence.

4.53 Patients attended court in 148 cases and contested 138 of them, although they only gave evidence in 95 of these cases. (See analysis by representation for further information).

Appeals

4.54 Section 18 detention orders expire after 6 months after which the order can be renewed by the patient's doctors without the need to return to court. The patient can appeal the renewal to the sheriff court. We wanted to find out how many of these renewals had been appealed. From the questionnaires, only 2 renewals were said to have been appealed. Information received from the Central Legal Office point to there having been about 30

appeals of this kind in 1997-1998. As the questionnaire returns covered almost 50 per cent of all the section 18 orders made in that year, a higher number than 2 would have been expected. The numbers are included here for the sake of completeness. It is possible that MHOs would not have known about patients' appeals if they were not involved in the renewal and the appeal process.

FURTHER ANALYSIS

Analysis by sex

4.55 After the above analysis had been completed, the questionnaire data were broken down by sex to see if there were any significant differences between them. In nearly all cases, differences between men and women were very small indeed and not significant.

4.56 Where differences are significant they are reported in the following section. These are dealt with in the context of the relevant court process.

Local authority

4.57 Although we can estimate the division of sexes between the local authorities, these were not matched by the results from the questionnaires. The biggest discrepancy was in Edinburgh, where there were twice as many male patients' questionnaires returned as women's. In fact, MWC data show us that the number of men and women detained under section 18 in Edinburgh is roughly the same.

Does the patient understand that they are subject to the section 18 detention?

- Of those patients who were said to understand that they were subject to the order, 87 per cent were men and 80 per cent were women.

Has the patient been subject to previous orders?

- Of those patients who had been subject to previous orders, 46 per cent were men and 53 cent were women, i.e. a difference of 7 per cent. As we have already noted above, this figure should be treated with caution.

Legal Aid

- There was a 5 per cent difference between the percentage of men (29%) in receipt of legal aid and the percentage of women(24%).

Did the patient attend court?

- There was a 3 per cent difference between the percentage of men attending court and the percentage of women.

Did the patient choose their own solicitor?

- Although the same percentage of men and women had legal representation in court, there was a 9 per cent difference between the percentage of men (27%) and women (18%) who chose their own solicitor.

Did the court appoint the patient's solicitor?

- There was a 6 per cent difference between the percentage of men for whom the court appointed a solicitor (8%) and the percentage of women (14%). This figure includes curators ad litem

Appointment of curator ad litem

- There was a 7 per cent difference between the percentage of men (6%) for whom a curator ad litem was appointed and the percentage of women (13%).

Was oral evidence given in court?

- There was a 5 per cent difference between the percentage of men's cases in which evidence was given and the percentage of women's cases.

Was the application contested?

- There was a difference of 6 per cent between the percentage of men who contested the application (30%) and the percentage of women (24%).

Representation in court

4.58 One of the aims of the research was to find out if representation in court had any impact on, or was affected by, other factors. In all the following figures, the 3 cases in which the patient was represented by family members are included.

Did the patient have legal aid?

4.59 Of those patients in receipt of legal aid, the vast majority (92% - 129/140) were represented in court. When patients were not in receipt of legal aid, they were unlikely to be legally represented in court. Only 12% of this group were represented. 11 patients were known to be legally aided but were not represented in court. It must be stressed that the figures refer only to representation in the court, that is the hearing. Some patients may have taken legal advice who were not then represented in court by a lawyer; the MHO may not have known about this.

4.60 In the case of 60 patients (11%) MHOs did not know if these patients had received legal aid. The numbers of that group who had and did not have representation were roughly equal.

Did the patient attend court?

4.61 There was a link between being represented in court and the patient attending court. 76 per cent of those patients who attended court had representation (113/148). Only 57 per

cent of those with representation attended court. Thus a significant number of patients were represented in court but did not attend themselves.

4.62 Over half the sample, 52 per cent, neither went to court nor were represented. In 44 per cent of cases, the patient had a presence in court, being either there in person or represented.

Was oral evidence given in court?

4.63 When patients were represented, oral evidence was more likely to be presented in court (68 per cent of 196 of cases). When patients were not represented, oral evidence was only given in 43 per cent of 298 cases. However, if we look at all the cases in which oral evidence was heard, the division between those who were represented and those who were not was very small (51% were, 49% were not).

Who gave evidence?

- Of the 95 cases in which the patient gave evidence, in the majority (78%) of cases the patient was represented.
- Where the patient was represented, the nearest relative was more likely to be called to give evidence.
- Unlike all other groups, MHOs were more likely to be called to give evidence where patients were not represented.
- A psychiatrist was much more likely to give evidence if a patient was represented. The difference was even greater for GPs where 89 per cent of GPs gave their evidence when the patient was represented and only 11 per cent gave evidence when they were not.

4.64 Evidence was given in 241 cases (51%). Evidence was almost as likely to be given in cases when patients were not represented as when they were. Also, representation did not automatically mean that oral evidence was called. In 32 per cent of cases where patients were represented, no oral evidence was called. Representation was, however, relevant to the type of evidence called. For example, a psychiatrist was more than 4 times more likely to be called if the patient was represented than if they were not (in 2 out of the 3 cases in which the patient was represented by family members, the psychiatrist was called).

Was the application contested?

4.65 Applications were more likely to be contested where the patient was represented. Of the 140 contested cases, in 89 per cent of them the patient was represented (overall, 38% of patients were legally represented). Conversely, only 15 patients (11% of contested cases) who were not represented contested their case.

More complex analyses

4.66 3 scenarios were considered in a further analysis. First we wanted to see in how many cases the patient had representation, the patient was present in court and oral evidence was given.

Table 4.11 Did the patient have representation/did the patient attend court/was oral evidence given?

Was oral evidence given in court?			Did the patient attend court?				Total
			Yes	% of total (N= 522)	No	% of total (N = 522)	
Yes	Did the patient have representation in court?	Yes	95	18	38	7	133
		No	28	5	98	19	126
	TOTAL		123	23	136	26	259
No	Did the patient have representation in court?	Yes	17	3	45	9	62
		No	7	1	164	31	171
	TOTAL		24	16	209	40	233

Missing data = 30 (6% of total N = 522)

- As we know, most patients did not attend court, most of them were not represented in court either and in just over half the cases, no oral evidence heard. This was the scenario for 31 per cent of cases, the largest group of patients (164 patients).
- In 98 cases (19% of the total 522 patients) patients did attend not court and were not represented but oral evidence was heard.
- 95 patients (18%) did attend court, did have representation and oral evidence was heard.
- 45 patients (9%) did not attend court, did have representation but no oral evidence was heard.
- 38 patients (7%) did not attend court, had representation and oral evidence was heard.
- 28 patients (5%) did attend court, had no representation and oral evidence was heard.
- 17 patients (3%) did attend court, had representation and no oral evidence was heard.
- The smallest group comprised the 7 patients (1%) who attended court, had no representation and no oral evidence was heard.
- In just under 20 per cent of cases, patients appear to have had quite an active role in their case, appearing in court, represented and with oral evidence being heard.

- In 44 per cent of cases the patient had a presence in court, being either there in person (41%) or having representation (36%).

4.67 These figures should be treated with care. They only record who was in court and do not tell us what went on during the hearing. Other scenarios give us a better idea of how actively the patient was involved in their case. In the first, we look at the interplay between the patient's representation (especially legal representation), attendance at court and contesting the application (Table 4.12). In the second, we look at patient's representation, attendance at court and the psychiatrist giving evidence (Table 4.13).

Table 4.12 Did the patient have representation/Did the patient attend court/Was the application contested?

Was the application contested?			Did the patient attend court?				Total
			Yes	% of total (N =522)	No	% of total (N =522)	
Yes	Did the patient have representation in court?	Yes	101	19	23	4	124
		No	15	3	0	0	12
	TOTAL		116	22	23	4	139
No	Did the patient have representation in court?	Yes	12	3	62	12	74
		No	20	4	268	51	288
	TOTAL		32	7	330	63	362

Missing data = 21 (4% of total N = 522)

- In the majority of cases (51%) patients did not attend court, were not represented and did not contest their case.
- In 101 cases (19%), however, patients did attend court, did have representation and did contest their case.
- In 62 cases (12%) the patient did not attend court, had representation and did not contest the case.
- In 23 cases, (4%) the patient did not attend court but was represented and did contest the case.
- In 20 cases (4%) the patient did attend court, was not represented and did not contest the case.
- In 12 cases (3%) the patient did attend court, was represented and did not contest the case.
- In 12 cases (3%) the patient attended court, was not represented and did contest the case.
- In no instances was it the case that the patient did not attend court, was unrepresented and contested the case.

4.68 The second largest group was made up of those patients who appeared to participate actively in the application, attending court with representation and contesting the case. In just under half of all the cases (45%), the patient had a presence in the court when the application was made, either in person or through a representative. We know from analysis of the data that out of the 48 cases where the patient was represented by a curator ad litem, in 15 of those the case was contested (that is 15/124 (12%) of the cases that were contested and the patient had representation).

4.69 The final scenario looks at the number of cases in which the psychiatrist was called to give evidence. Such a scenario would imply that the application was being tested with some vigour if the psychiatrist was being called to the court to explain why they thought the patient should be detained.

Table 4.13 Did the patient have representation/Did the patient attend court/Did the psychiatrist give evidence?

Did the psychiatrist give evidence?			Did the patient attend court?				Total
			Yes	% of total (N =522)	No	% of total (N =522)	
Yes	Did the patient have representation in court?	Yes	69	13	10	2	79
		No	12	2	5	1	17
	TOTAL		81	15	15	3	96

Missing data or not applicable = 426 (82% of total N = 522)

- In 69 cases (13%) the patient attended court, was represented and the psychiatrist was called to give evidence.
- In 12 cases (2%) the patient attended court, was not represented and the psychiatrist was called to give evidence.
- In 10 cases (2%) the patient did not attend court, but was represented and the psychiatrist was called to give evidence.
- In 5 cases (1%) the patient did not attend court, was not represented and the psychiatrist was called to give evidence.

Analysis by local authority

4.70 Whilst the figures above present the national picture of practice in the courts, an analysis of the findings by local authority shows the diversity of practice across the country. Any figures produced at this level of analysis must be treated with caution as returns from some local authorities were very low, notably Dumfries & Galloway and Stirling.

4.71 The following section contains summaries of the main findings from the questionnaires broken down by local authority. It should be noted how the findings from some local

authorities are so much higher or lower than the average that they will skew the national findings presented above.

Sex

4.72 As has already been mentioned, the ratio between the sexes in the questionnaire returns was roughly the same as that for the total sample. The main exception to this was Edinburgh where responses for men were almost double those for women, although an almost equal number of men and women are detained in that local authority.

MHO attendance at court

4.73 MHOs attended court in 87 per cent of cases and in most local authorities MHOs attended court most of the time. In 18 local authorities the MHO attended in every case. There were only 4 local authorities where non-attendance by the MHO occurred on a more regular basis: Aberdeenshire, Aberdeen City, Dundee City and Highland councils all had a significant number of hearings where the MHO had not appeared. Indeed, the MHO only attended court in a fifth of the Dundee cases.

Patient attendance at court

4.74 On average, only 28 per cent of patients attended their court hearing. However, the rates at which patients attended varied considerably around the country. Whilst the numbers are often small, and so the data should be interpreted carefully, in Falkirk and Moray, in most cases patients attended court (70% and 67% respectively). In contrast, none of the 19 patients in West Lothian attended their hearings and patient attendance was a rare occurrence in Aberdeen (15%), Aberdeenshire (11%), East Renfrewshire (8%), Edinburgh (8%), Highland (5%), Midlothian (6%) and Perth & Kinross (6%).

Patient representation

4.75 Variations between local authorities were particularly wide in this category. Patients were represented in 39 per cent of cases. Only in Falkirk, Fife, Glasgow and the Scottish Borders were patients more likely than not to have legal representation. In Falkirk 83 per cent of patients were said to have representation in court whilst the figure was 92 per cent for the Scottish Borders.

4.76 By contrast, in East Renfrewshire only one out of 14 patients (7%) had representation and 15 per cent of patients had representation in Edinburgh. In Midlothian no-one was said to have had representation in court.

4.77 The questionnaire asked if patients had had representation in court. As the data from the Scottish Legal Aid Board show (see pages 30-39) this does not necessarily mean that they went through the application process without having any legal advice. It is possible that they received legal advice before the court hearing and chose not to contest the case or did not wish to be represented at the hearing.

Did the patient choose their own solicitor?/Did the court appoint the patient's solicitor?

4.78 In most cases the numbers in each sample were very small. In the majority of cases where the patient was legally represented (200 cases) they chose their own solicitor. The exception to this was Angus, where the court appointed the patient's solicitor in 6 cases (40%).

Did the court appoint a curator ad litem?

4.79 Curators ad litem were appointed in 48 cases. 22 of these came from Scottish Borders where curators ad litem were appointed in all but 2 cases (data are missing for one case). Curators ad litem were appointed in 11 authorities: Aberdeen, Aberdeenshire, Angus (where 4 curators ad litem were appointed), Argyll & Bute, Dundee, Falkirk, Fife, Glasgow, Perth & Kinross, Borders and West Dunbartonshire.

Local authority representation

4.80 In just over 40 per cent of cases the local authority was legally represented at the court hearing.

4.81 Authorities varied in terms of the extent to which they were represented in court. In all 23 of the Falkirk cases and the vast majority of the cases heard in Aberdeenshire, Angus, Fife, Highland, Moray, North Ayrshire and the Borders, the authority was legally represented. In all these authorities, except Highland, the MHO was also usually in attendance. Stirling and D&G were represented in both of their cases.

4.82 By contrast, in Argyll & Bute, East Renfrewshire, Edinburgh, Glasgow, Midlothian, Perth & Kinross, West Dunbartonshire and West Lothian the local authority was rarely represented, though in all 8 of these authorities the MHOs always attended court. Further, in Argyll & Bute, East Renfrewshire, Edinburgh, Midlothian and Perth & Kinross, the patient rarely had a lawyer either. So in these authority areas, detention cases appear to have been heard without a lawyer appearing before the sheriff for either side most of the time.

4.83 In Glasgow and West Dunbartonshire it appeared that the patients were more likely to be represented than the local authority.

4.84 Falkirk appears to be unique. In that in 70 per cent of cases local authority decisions were taken with the local authority represented by both the MHO and a lawyer and the patient represented by a lawyer with the patient also at court. By contrast, in Midlothian, in nearly all cases applications were heard with only the MHO present in court.

4.85 A number of factors could explain these variations: the culture of the local court, the lack of recognised expertise in the local legal profession, or patients' unwillingness to contest cases.

Evidence

4.86 Oral evidence was given in 50 per cent of cases and evidence was heard in some cases in all local authorities. Figures were lowest in Aberdeen (12%), Dundee (17%), Highland (16%), Borders (16%) and South Ayrshire (20%).

4.87 The patient gave evidence in 18 per cent of cases and in most local authorities, the patient rarely gave oral evidence to the court. The exceptions to the rule were Falkirk, where patients were said to have given evidence in 13 cases (57%), and Moray, where patients gave evidence in 8 cases (67%).

4.88 Nearest relatives gave evidence in only 17 (4%) cases and in only 9 authorities (East Renfrewshire, Falkirk, Fife, Glasgow, Inverclyde, Midlothian, North Ayrshire, North Lanarkshire, West Dunbartonshire). Again, Falkirk had the highest number, with 4, but these still accounted for only 17 per cent of the cases from that local authority.

4.89 As we already know, the biggest group to give evidence was the MHOs themselves, who gave evidence in 210 (44%) cases. Practice varied enormously across the country with all MHOs said to give evidence in Moray and only 4 per cent and 5 per cent in Aberdeen and Dundee respectively.

4.90 Psychiatrists gave evidence in 96 (18%) of cases. Again, in Falkirk and Moray psychiatrists gave evidence in the majority of cases (83% in both) with only Fife having the other significant number of 13 (54%). Although 60 per cent of Glasgow patients were represented in court by a solicitor, in only 5 cases (10%) was the psychiatrist called upon to give oral evidence to the court. Legal representation would not therefore appear to equate with extensive cross-examination of the main medical witnesses in these cases. Psychiatrists were not called in any case in Dumfries & Galloway (but note small returns), East Ayrshire, East Dunbartonshire, Inverclyde, Midlothian and West Lothian.

4.91 GPs gave evidence in fewer cases (70 (13%)) than did psychiatrists. Falkirk had 18 (78%) cases in which this occurred. Again GPs were not called at all in Argyll & Bute, East Ayrshire, East Dunbartonshire, Inverclyde, Midlothian, South Lanarkshire, West Dunbartonshire and West Lothian.

Was the case contested?

4.92 We know that 27 per cent of cases were contested. In only Falkirk (65%) and Moray (67%) were more than 60% of the cases contested. In Inverclyde, Midlothian and West Lothian, no cases were contested at all.

CHAPTER 5

CASE STUDIES

Introduction

5.1 The MWC and MHO data provided national statistics on the operation of the Act. The purpose of the case studies (and the interviews) was to provide an in-depth picture of the court process using data that were not available from any other source. These findings are not representative of the national picture, but they do show how three courts deal with the demands of the Act and the Court Rules. The purpose of this part of the study was to find out more about the court procedures and to see how court practice interacts with the rest of the mental health system. With this in mind, the studies are organised as follows:

- Description of practice and procedures in the court
- Time –scales

5.2 In interviews, respondents pointed to two particular problems associated with time scales. One was the tendency by doctors to wait until a section 26 order has almost expired before applying for the section 18 order. This reduces the time available for MHOs and patients to prepare for the application. The second was the short notice of hearings given to patients, allowing them little time to instruct a solicitor. Court data were analysed to find out the extent of these problems.

- Legal representation
- Patient attendance
- Evidence
- Continuations

5.3 Once the case has started, the hearing of the application may be adjourned for any number of reasons. This could, potentially, extend a patient's period of detention by weeks and even months, thus it was of interest to find out how often this happened.

- Contested cases
- Decision
- Medical reports

5.4 Solicitors expressed concern about the brevity and content of some doctors' reports in section 18 applications, especially GPs' reports. They also thought that they are unduly influenced by psychiatrists' recommendations and that forms were filled in wrongly. It was suggested that in their reports, psychiatrists and GPs over-emphasise the risks a patient may pose to others and the extent of patients' non-compliance with medication and lack of insight into their conditions. Because they are so crucial to the decision-making process (often in the absence of any other evidence) these comments merited some attention.

- Other reports

5.5 Where relevant, note was taken of other reports filed with the court in the hearing. These reports supplemented the, mainly medical, evidence before the court and potentially offered the court a wider perspective on the case.

5.6 The findings from the three case studies are presented in this chapter, each court at a time, with a summary of these findings. For reasons of confidentiality, the three courts are identified only by the letters A, B and C at the end of each court study.

COURT A

PRACTICE AND PROCEDURE

5.7 Court A dealt with the largest number of applications lodged in the study period (218). Applications are accepted from 6 hospitals and 5 local authorities and the court deals with, on average, 2 to 3 Mental Health Act applications daily (these include other orders under the Act such as guardianship). All sheriffs hear mental health applications as and when they are called upon to do so.

5.8 Court A has an administrator dedicated to ensuring that mental health applications are processed as efficiently as possible. Court staff are issued with desk procedures, which outline the requirements of the Act and draw attention to the specific way in which prescribed forms must be completed. Staff aim to get the applications back to the hospital to be served on the patient on the day they are submitted. At the very least they attempt to give doctors 48 hours' notice of the hearing.

5.9 A list of legal representatives who are experienced in dealing with mental health issues is sent with the papers to the hospital. A specialist legal representation service is available in the Court A area (unlike the other two courts). The first calling of a case is used to assess what representation a patient may have or require. If the patient is unrepresented, the sheriff may appoint a solicitor or curator ad litem for them. This is often done in a very informal way with discussions between the sheriff and solicitor about how the best interests of the patient may be served. Three curators are used regularly in the area. All are solicitors with experience in mental health and one has a nursing background. If a second psychiatric opinion is required, solicitors will instruct the psychiatrist before a continuation is granted by the

sheriff. This speeds up the process since a sheriff will usually wish to receive the report within 7-10 days.

5.10 Written reports by health professionals and the MHOs are read by the sheriff prior to a hearing and again during a hearing. If a sheriff wishes to see a more detailed report or requires clarification of a particular aspect of the application then a supplementary report will be submitted or a doctor called to clarify a point. Oral evidence is often taken from MHOs and submissions taken from agents to speed up the decision-making process. Hearings are held in the Sheriff Court. These are generally informal with all concerned sitting around a table with the sheriff behind the dais. No gowns are worn.

5.11 When the case is completed, the papers are sent to the hospital with the patient. Only the papers for unsuccessful or withdrawn applications are kept at the court but details of the application are noted in a large ledger. However, in this year, the decisions of 75 of the 218 section 18 applications granted in Court A were not recorded in the ledger. The sheriff clerk thought that about 65 of these applications had been granted. This was based on her memory and knowledge of practice in the court. Researchers assumed that this was a clerical oversight on the part of the court staff.

5.12 Because it was not possible to look at the case papers in the court, access was granted to the same papers kept by the MWC.

DATA COLLECTION

Number of orders

5.13 91 section 18 applications were analysed out of a total of 218 applications made in this year. This included 13 applications that were unsuccessful or withdrawn and represents 41% of all applications made in that year.

Timescales

Period between date of application and expiry of current section

5.14 Section 26A allows doctors to apply for a further five days, detention when a section 26 order is due to expire and it is not practicable to apply for a section 18 order. This was done on two occasions in Court A.

5.15 As Table 5.1 shows, in 46 per cent of cases, the section 18 application was made when the section 26 order was due to expire in four days or fewer. A further 21 per cent of applications were made when five to eight days remained of the section 26 order. In three cases (4%) the section had expired before the application had been made.

Table 5.1 Number of days between date of application and expiry of current section

	Number	% (N = 77)
Same day	6	8
1 day	9	12
2 days	8	10

3-4 days	12	16
5-6 days	10	13
7-8 days	6	8
9-10 days	8	10
11-13 days	5	6
14-21 days	6	8
Section expired before application made	3	4
Missing data	4	5
TOTAL	77	100

Notice given to patients

5.16 Sheriff Court rules do not prescribe how many days' notice of a section 18 hearing should be given to patients. In theory, a patient may be told that the application is to be heard on the day of the hearing, which makes it difficult for them to instruct a solicitor. It was possible to work out how many days' notice had been given to patients in 65 per cent of cases. In the other 35 per cent of cases, the date on which the responsible medical officer informed the patient of the hearing was missing from the records.

5.17 Table 5.2 shows that in 31 per cent of cases, patients were given fewer than three days' notice of the hearing with 26 per cent having between three and six days' notice. In three cases the patient was informed of the application after the hearing date, because of illness or because they had absconded from hospital.

Table 5.2 Number of days' notice given to patient

	Number	% (N = 91)
Same day	3	3
1 day	18	20
2 days	7	8
3-4 days	16	18
5-6 days	10	11
7 days	1	1
8 days or more*	1	1
Patient informed after the hearing**	3	3
Missing data	32	35
TOTAL	91	100

*This was over the Christmas/New Year period

**Patient absconded from hospital or was ill

Period of time between expiry of section 26 and decision

5.18 Out of the 77 relevant cases (where the patient was subject to a section 26 order when the section 18 application was made), in 14 per cent of cases the section 18 order was granted before the section 26 order expired. In 47 per cent of cases (35) the section 18 order was granted 7 days or more after the section 26 had expired. There were continuations in 26 of these cases.

Table 5.3 Period of time between expiry of section 26 and decision

	Number	% (N = 77)
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s18 granted before s26 expired	11	14
s18 granted on same day as s26 expired	2	3
1-2 days	7	9
3-4 days	10	13
5-6 days	8	10
7-14 days	23	30
15 days or more	13	17
Missing data	4	5
TOTAL	78	*100

*Percentages do not add up to 100 due to rounding

Legal representation

5.19 It was not always clear whether a patient had been legally represented, although notes of who addressed the court are sometimes given on the Form 2. Notes of telephone calls from solicitors provided another way of picking up this information. Because not all court papers are sent to the MWC, this sort of information was missing in many cases and may account for the 31 per cent of cases where it was not possible to say whether the patient was legally represented or not.

5.20 However, it was possible to show that in just under half of all cases (49%) the patient was represented, and definitely not represented in only 14 per cent of cases. A curator ad litem was appointed in only three cases (3%) whilst an advocate was used in one case.

Patients' attendance at the hearing

5.21 In 31 per cent of cases, the patient was recorded as having attended the hearing. Again, data are missing in a third of cases but the patient definitely did not attend in 23 percent of cases.

Evidence

5.22 In the majority of cases (64%) no evidence was heard. The patient gave evidence in 9 per cent of cases. This data come from the Form 2, which is used to record who gave evidence at the hearing.

Continuations

Number of continuations

5.23 As shown in Table 5.4, in just under half of all cases (49%) there were no continuations, and in 31 per cent of cases there was just one. In only 5 cases were there 3 or more continuations.

Table 5.4 Number of continuations

	Number	% (N = 91)
None	45	49
1	28	31
2	11	12

3	4	4
4 or more	1	1
Missing data	2	2
TOTAL	91	*100

*Percentages do not add up to 100 due to rounding

Reasons for continuations

5.24 In the majority of cases, the case was adjourned to obtain a second psychiatric opinion. However, in only 9 cases was a psychiatrist's report included in the court papers. The patient is not obliged to show such a report to the court. The figures in Table 5.5 would imply that while many cases are adjourned for this reason, in few cases does this lead to the court having further psychiatric evidence before it when it makes its decision.

Table 5.5 Reasons for continuations

	Number	% (N = 46)
To instruct a solicitor	3	7
To obtain a second psychiatric opinion	31	67
Papers not served	3	7
Other reason	2	4
None given	4	9
Missing data	3	7
TOTAL	46	*100

*Percentages do not add up to 100 due to rounding

Contested cases

5.25 Court papers do not record specifically whether a patient contested a case so other indicators have to be used to measure the extent of patients' non-consent to the application. One indication is whether evidence was called. This occurred in 30 per cent of cases. In Court A, the sheriff clerk was of the view that when a case is to be contested, a second psychiatric opinion is sought. This occurred in 31 cases (34%).

Decision

5.26 As all unsuccessful applications were recorded, it is possible to say that in only 4 cases (4%) was the order not granted. Nine applications were withdrawn (10%). The order was granted in the remaining 78 cases (86%).

MEDICAL REPORTS

The requirements of the Act

5.27 The evidential basis of a section 18 application is made up of the medical reports provided by a psychiatrist and another doctor (usually the patient's GP).

GPs

5.28 Although in most cases the patient's GP will provide a medical report, in some cases this is not possible. In such cases, the doctor in question is required to explain on the Form 3 why it was not practicable to obtain a report from a doctor who knows the patient. In seven cases in Court A, the doctor providing the patient's report was not the patient's GP. Such cases were likely to involve long-stay patients, homeless persons and where a GP was unable to attend to see the patient.

Non-compliance and lack of insight

5.29 Table 5.6 shows that in 36 per cent of cases the psychiatrist's report stated that the patient would not comply with the medication prescribed by doctors. In 31 per cent of cases the GP's report mentioned non-compliance.

Table 5.6 Non-compliance with medication

Non-compliance mentioned in medical reports	Number	% (N = 91)
Psychiatrist	33	36
GP or other doctor	28	31

5.30 Lack of insight was mentioned as a reason for the application in 11 per cent of psychiatrists' reports and in 15 per cent of GPs' reports.

Table 5.7 Lack of insight

Lack of insight mentioned in medical reports	Number	% (N = 91)
Psychiatrist	10	11
GP or other doctor	14	15

5.31 Both non-compliance and lack of insight were mentioned in 19 per cent of psychiatrists' reports and 20 per cent of GPs' reports.

Table 5.8 Non-compliance and lack of insight

Non-compliance and lack of insight mentioned in medical reports	Number	% (N = 91)
Psychiatrist	17	19
GP or other doctor	18	20

5.32 In total, therefore, non-compliance was mentioned in 55 per cent of psychiatrists' reports and in 51 per cent of GPs' reports. Lack of insight was mentioned in 30 per cent of psychiatrists' reports and in 35 per cent of GPs' reports

Risk to others

5.33 As Table 5.9 shows, only 2 per cent of psychiatrists' reports and 4 per cent of GPs' reports stated that the patient posed a risk to other people.

Table 5.9 Risk to others

Risk to others mentioned in reports	Number	% (N = 91)
Psychiatrist	2	2
GP or other doctor	4	4

Risk to self

5.34 The number of doctors citing patients' risk to themselves was higher than the number citing a risk to others: 13 per cent of psychiatrists and 12 per cent of GPs (see Table 5.10).

Table 5.10 Risk to self

Risk to self mentioned in reports	Number	% (N = 91)
Psychiatrist	12	13
GP or other doctor	11	12

5.35 5 per cent of psychiatrists and of GPs stated that patients posed a risk both to others and to themselves (Table 5.11).

Table 5.11 Risk to others and to self

Risk to others and to self mentioned in reports	Number	% (N = 91)
Psychiatrist	5	5
GP or other doctor	5	5

5.36 In total, risk to others was mentioned in 7 per cent of psychiatrists' reports and in 9 per cent of GPs' reports and risk to themselves was mentioned in 18 per cent of psychiatrists' reports and 17 per cent of GPs' reports.

A note on coding reports

5.37 Form 3 has space for two medical reports. Both must be filled in by the doctor. One describes the patient's mental state and the other indicates why other methods of care/treatment are not suitable. In total, therefore, each application will include 4 short reports on the patients' illness and treatment.

5.38 It was agreed that if any one of the four reports was particularly brief or illegible then it would be recorded as an application containing a brief or illegible report. Therefore, the number of applications recorded relates to the number of those containing full, legible reports, not to the total number of reports.

5.39 The analysis set out below must be read with the caveat (mentioned in the section on evidence) that informal information exchange is not recorded on court papers. From interviews, we know that parties, solicitors, sheriffs and clerks may discuss cases both inside and outside the court-room. Such discussions may inform the sheriff about the patient's case and may supplement the information supplied on the papers. Nevertheless, as concern had been expressed about the brevity and legibility of medical reports the reports were analysed to verify the basis of these concerns.

The brevity of medical recommendations

5.40 It is possible (in fact it may be regarded as a skill) to say a great deal about a person in very few words. For example, a patient may have made numerous suicide attempts, be refusing food and be insistent on going home. This could be expressed in few words but would convey a great deal about the patient's mental disorder. On the other hand, as scrutiny of the medical reports on the court files showed, some doctors used very few words to tell the court very little about the patient's illness or the treatment required.

5.41 In analysing the forms, a very brief report was defined as one in which 12 words or fewer had been used either to explain the patient's illness or why the order was required. A brief report was one which used 20 words or fewer. Very brief reports were written in 32 per cent of cases and brief reports were written in 16 per cent of cases, a total of 48 per cent.

Table 5.12 How brief were medical recommendations?

Brevity of medical recommendations	Number	% (N = 91)
12 words or fewer	29	32
12 - 20 words	15	16
Not brief	47	52
TOTAL	91	100

The legibility of medical recommendations

5.42 All medical reports were hand-written. Legibility was defined as the ability of an experienced researcher, used to dealing with documentary evidence, to read a hand-written report, which has been photocopied. This assessment is subjective and sheriffs will see original forms, not photocopies. However, the analysis was conducted to find out if concerns expressed by interview respondents were justified. Also legibility posed sufficient difficulties for some sheriffs in the court to lead them to request that medical recommendations be typed.

5.43 In 22 per cent of cases one of the medical reports was illegible in part or in whole.

MHO AND OTHER REPORTS

5.44 Table 5.13 sets out the reports that were available to the court when the application was heard. In all cases, the doctors would have filled in Form 3 with a report outlining why the order was required. In addition to this, in 64 per cent of cases the court had additional information from the MHO in the form of either a separate report and/or a Social Circumstances Report (SCR).

5.45 In 10 per cent of cases additional psychiatric evidence was available to the court.

Table 5.13 Number of MHO and other reports

	Number	% (N = 91)
MHO report on Form 2 only	17	19
Separate MHO Report only	41	45
MHO + SCR	17	19

MHO + Psychiatrist's report	7	8
MHO + Psychiatrist's report + SCR	2	2
Missing data	7	8
TOTAL	91	100

APPEALS

5.46 There were two appeals against renewals of detentions. One was withdrawn and one was unsuccessful. No further information is available about either appeal.

SUMMARY

5.47 Court A is a large urban court that hears applications from several local authorities and hospitals. The court reported no difficulties in administering the Act, possibly aided by the ease with which hearings can be placed before a sheriff on any day of the week. In just under half of the cases looked at, applications came into the court when the section 26 order had 4 days or fewer to run. An equal number of orders was granted 7 days or more after the section 26 order had expired. In roughly a third of cases, the patient had less than 3 days' notice of the hearing.

5.48 The patient was definitely represented in about half of all cases (though data were missing and this figure could have been higher) with a curator ad litem appointed in just 3 cases. A pool of experienced local solicitors is available and a list of solicitors is sent to the hospital with notice of the hearing. Patients attended court in about a third of cases (again data were missing) and in nearly two-thirds of cases no oral evidence was heard. Continuations were widespread, occurring in half of all the cases looked at, mainly to obtain a second psychiatric opinion. However, few of these reports appear to have been seen by the court.

5.49 In the medical reports, non-compliance with medication or treatment was given as a reason for the detention in over half of all psychiatrists' and GPs' reports. Lack of insight was given in fewer cases: 30 per cent and 35 per cent respectively. Risk to others or to self was mentioned in less than 20 per cent of doctors' reports. Just under a third of doctors' reports were very brief (12 words or fewer) and just over 20 per cent were illegible in whole or in part.

5.50 Unlike the other two courts, in Court A, in many cases, the court was provided with separate reports from the MHO, including, in some cases, a full Social Circumstances Report.

COURT B

PRACTICE AND PROCEDURE

5.51 Court B is a large urban court. Most of the applications it hears come from one local hospital with occasional applications from two other hospitals in the area. Two sheriffs hear the majority of the applications and hearings are fitted in around other court business to comply with statutory time-scales. When a section 18 application arrives all other business is set aside.

5.52 The sheriff clerk and the Medical Records Officer (MRO) at the local psychiatric hospital work closely together to ensure the efficient administration of the Act. The sheriff clerk liaises with sheriffs and solicitors and the MRO liaises with the patient, clinicians, relatives and GPs. Court papers are picked up from the court by a taxi and driven to the

hospital where they are returned to the MRO who informs the doctors of the date and place of the hearing; they, in turn, serve the patient with the papers. The signed Form 3 indicating that the patient has received the papers is then returned to the court, again in a taxi. Taxis are used to ensure that the application can be received and dealt with on the same day. The taxi is paid for by the hospital.

5.53 When the MRO receives the application from the Responsible Medical Officer (RMO) they will inform all relevant parties. A diary system is used to indicate when renewals are due and section 26 orders expire. Reminders are sent out to all clinicians regarding these. Doctors are discouraged from lodging applications on Fridays, which can make it more difficult to inform parties of the application quickly. The aim of these procedures is to save court time and prevent adjournments.

5.54 If, after being served with the court papers, the patient states that they wish to oppose the application or to be represented, the MRO will arrange for legal representation. The sheriff, with the advice of the clerk and the MRO, will assess whether the patient can give instructions (and therefore be represented by a solicitor) or whether a curator ad litem should be appointed. A curator is always appointed if a child is the subject of an application. If there are any doubts as to whether a patient will contest an order a curator is appointed and if the patient states that they do not wish to be represented, the court may still appoint a solicitor for them. The solicitor or curator ad litem will endeavour to see the patient before the first hearing; if the patient does not then wish to oppose, the court will be informed and the case will be heard unopposed.

5.55 Most applications are unopposed and are dealt with in chambers with only the sheriff and sheriff clerk present. When an application is opposed, hearings are held at local psychiatric hospitals, including the local Young Persons' Unit. Solicitors and the MRO will inform the clerk if the application is likely to be opposed; in such cases the first hearing will be in chambers and a date appointed for a full hearing.

5.56 Opposed hearings are held in the hospital with all parties sitting around a table in a room set aside for the hearings. The sheriff will try and adapt the hearing to the patient, allowing them to comment when appropriate. Evidence is heard in few cases and very few second opinions are lodged - only one was found on the court papers in the year covered by the study.

Number of orders

5.57 Court B dealt with 56 orders in this year. All but one order was granted.

Timescales

Period between date of application and expiry of current section

5.58 In 45 per cent of cases the section 18 application was made when the section 26 order was due to expire in four days or less (see Table 5.14).

Table 5.14 Number of days between date of application and expiry of current section

	Number	% (N = 56)
Same day	2	4
1 day	6	11
2 days	5	9
3-4 days	12	21
5-6 days	10	18
7-8 days	9	16
9-10 days	2	4
11-13 days	4	7
14-21 days	4	7
Missing data	2	4
TOTAL	56	*100

*Percentages do not add up to 100 due to rounding

Notice given to patients

5.59 In 27 per cent of cases the patient was given less than three days' notice of the hearing and 64 per cent of patients were given between three and six days' notice. In no cases was the patient informed on the day of the hearing.

Table 5.15 Number of days' notice given to patient of hearing

	Number	% (N = 56)
Same day	0	0
1 day	4	7
2 days	11	20
3-4 days	17	30
5-6 days	19	34
7-9 days	2	4
Missing data	3	5
TOTAL	56	100

Period of time between expiry of section 26 and decision

5.60 Table 5.16 sets out the number of days between the expiry of the section 26 and the decision by the court on the section 18 application. In 31 per cent of cases the section 18 order was granted before the section 26 had expired. In 22 per cent of cases (12), seven or more days had passed between the two events. In all 12 of these cases, the case was adjourned at least once.

Table 5.16 Period of time between expiry of section 26 and decision

	Number	% (N = 56)
s18 granted before s26 expired	17	31
s18 granted on same day as s26 expired	3	5
1-2 days	9	16
3-4 days	9	16
5-6 days	4	7
7-14 days	6	11
15 days or more	6	11
Missing data or not applicable	2	4
TOTAL	56	*100

*Percentages do not add up to 100 due to rounding

Legal representation

5.61 Patients were legally represented in 38 per cent of cases. These data were collected from notes on the court record which stated that a solicitor had been appointed either by the patient or the court. It does not follow that the solicitor attended court.

5.62 A curator ad litem was appointed in 18 per cent of cases, the highest number in the three courts.

Further information about legal representation

5.63 It was possible to obtain further information about the way patients come to be legally represented in Court B. The Form 3 that is used to show that the patient has been informed of the hearing must also be used to show whether the patient wishes to attend the hearing or to be represented. Scrutiny of these forms and the court papers showed the following:

- In 9 cases the patient chose their own solicitor, one of whom was appointed to act as a curator ad litem by the court.
- In 4 cases, the patient asked the court to nominate a solicitor. In 2 of these cases the court appointed a curator ad litem.
- In 8 cases, the patient indicated on the Form 3 that they did not wish to be represented but the court did appoint a solicitor for them. In 5 of these cases the court appointed a curator ad litem.
- In 3 cases, the patient did not wish to be represented but the court appointed a curator ad litem to act in their interests in the hearing.

Patients' attendance at the hearing

5.64 As with contested cases, it was impossible to say from court records whether the patient attended the hearing. When a patient has been served with notice of the hearing, the RMO fills in a Form that is returned to the court. The form states that the application has been served on the patient and also whether the patient wishes to attend the hearing. In Court B, 48 per cent of patients were recorded as saying that they wished to attend the hearing. From interviews and from notes on the case files, it seems unlikely that this percentage of patients did attend the hearing. A figure of 23 per cent (see next paragraph) is probably closer.

Evidence

5.65 Evidence was recorded as having been heard in 23 per cent of cases. The patient gave evidence in 11 per cent of cases.

Continuations

Number

5.66 There were no continuations in 79 per cent of cases. In 18 per cent of cases there was only one continuation (see Table 5.17).

Table 5.17 Number of continuations

	Number	% (N = 56)
None	44	79
1	10	18
2	1	2
3	1	2
TOTAL	56	*100

*Percentages do not add up to 100 due to rounding

Reason

5.67 The largest number of continuations (6) were granted to obtain a second psychiatric opinion.

Table 5.18 Reasons for continuations

	Number	% (N = 15)
To allow solicitor/curator to take instructions/finish investigation	3	20
To obtain a second psychiatric opinion	6	40
Witness unable to attend	2	13
Other reason	2	13
None given	2	13
TOTAL	15	*100

*Percentages do not add up to 100 due to rounding

Contested cases

5.68 As in the other courts, it was not possible to say definitely whether the case was contested or not. If the same indicators are used as in court A then it can be said that in 23 per cent of cases evidence was called and in 6 cases (11%) a second psychiatric opinion was sought. In 21 cases (38%) a solicitor was appointed to act for the patient, although in 8 of these cases the patient had said that they did not wish to be legally represented.

Decision

5.69 The order was granted in 98 per cent of cases and not granted in only one case.

MEDICAL REPORTS

Analysis of medical reports

5.70 Due to time constraints it was not possible to analyse the medical reports in all the cases. Cases were kept in the court in chronological order; every other case was chosen (a total of 28 cases). The results are set out below.

5.71 In 88 per cent of cases the patient's own GP completed the Form 3 medical report.

Table 5.19 Status of doctor who saw patient

Status of Doctor who saw patient	Number	% (N = 56)
Patient's GP	49	88
Not patient's GP	7	13
TOTAL	56	100

5.72 There were 7 cases where the patient's own GP did not write a report. In 5 cases the GP used was one who worked part-time at the hospital. The reasons given for not using the patient's own GP were as follows:

Table 5.20 Reason for GP's non-attendance

Reason for own GP's non-attendance	Number
Long-term hospital patient - no community GP	2
Patient resident in another part of the country - own GP unable to attend	3
GP not available	1
No reason given	1

Non-compliance with medication

5.73 In 21 per cent of cases psychiatrists stated that the patient would not comply with medication. The GP said the same in 25 per cent of cases.

Table 5.21 Non-compliance with medication

Non-compliance mentioned in medical reports	Number	% (N = 28)
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Psychiatrist	6	21
GP or other doctor	7	25

Lack of insight

5.74 In only one case (4%) did the psychiatrist say that the patient lacked insight into their illness. The corresponding figure for GPs was 21 per cent.

Table 5.22 Lack of insight

Lack of insight mentioned in medical reports	Number	% (N = 28)
Psychiatrist	1	4
GP or other doctor	6	21

5.75 Psychiatrists stated that the patient would not comply with medication and lacked insight in 36 per cent of cases. The corresponding figure for GPs was 18 per cent.

Table 5.23 Non-compliance with medication and lack of insight

Non-compliance and lack of insight mentioned in medical reports	Number	% (N = 28)
Psychiatrist	10	36
GP or other doctor	5	18

5.76 In total, therefore, non-compliance with medication was cited as a reason by psychiatrists in 57 per cent of cases and by GPs in 43 per cent of cases. Lack of insight was cited by equal numbers of psychiatrists and GPs - in 39 per cent of cases.

Risk to others

5.77 In 11 per cent of psychiatrists' reports and 11 per cent of GPs' reports, the patient's illness was said to be a risk to others. The number of patients said to be a risk to themselves was higher: 32 per cent of psychiatrists and 39 per cent of GPs cited this as a reason for the application.

Table 5.24 Risk to others

Risk to others mentioned in report	Number	% (N = 28)
Psychiatrist	3	11
GP or other doctor	3	11

Risk to self

Table 5.25 Risk to self

Risk to self mentioned in report	Number	% (N = 28)
Psychiatrist	9	32
GP or other doctor	11	39

Risk to others and risk to self

Table 5.26 Risk to others and risk to self

Risk to others and risk to self mentioned in medical reports	Number	% (N = 28)
Psychiatrist	0	0
GP or other doctor	3	11

5.78 In total, psychiatrists stated that the patient was a risk to others in 11 per cent of cases and GPs thought this in 22 per cent of cases. The corresponding figures for risk to themselves was 32 per cent of psychiatrists and 50 per cent of GPs. The differences between the psychiatrists and GPs was noticeably wide.

The brevity of medical recommendations

5.79 In 25 per cent of cases a medical report consisted of 12 words or fewer and in 46 per cent of cases a medical report consisted of 12 to 20 words, a total of 71 per cent.

Table 5.27 How brief were medical recommendations?

Brevity of medical recommendations	Number	% (N = 28)
12 words or fewer	7	25
12 - 20 words	13	46
Not brief	8	29
TOTAL	28	100

The legibility of medical recommendations

5.80 In 39 per cent of cases, medical recommendations included a report that was illegible in part or (in one case) in whole.

MHO AND OTHER REPORTS

5.81 In only one case was a separate MHO report included with the court papers and this came from an MHO from a different local authority from all the other cases in Court B.

APPEALS

5.82 There was one section 30 appeal in Court B. The patient was male and was represented by a solicitor. Oral evidence was given in the hearing and the appeal was dismissed.

SUMMARY

5.83 Court B is an urban court that hears applications from one large local authority and mostly from one local hospital. A highly efficient hospital administrator and close relations between court and hospital ensured that there were no major problems in administering the Act. As in Court A, in just under a half of all cases, applications came into the court when the section 26 order was due to expire in 4 days or less. In just under a third of cases, the section

18 order was granted before the section 26 had expired (this was far higher than the corresponding figure in Court A (14 %) and higher than in Court C (24%)). In just over a quarter of cases the patient was given less than 3 days' notice of the hearing.

5.84 Of the three courts, Court B most actively involved itself in obtaining what it considered to be appropriate legal representation for patients. This perhaps explains why 18 per cent of patients were represented by a curator ad litem, the highest figure amongst the three. Solicitors or curators ad litem were appointed to act for patients in just under 40 per cent of cases. Most solicitors acting in these cases are very experienced in mental health work. Just under half of patients indicated that they wished to attend the hearing. However, it seems unlikely that this number did attend, judging from the number of cases in which evidence was heard (less than a quarter) and from notes on the court papers of telephone calls from solicitors stating that their client would not be contesting the application. If the application was not contested, the case would be dealt with in chambers with only the sheriff and clerk present.

5.85 Continuations occurred in just over 20 per cent of cases. 6 of these were granted to obtain a second psychiatric opinion but only one such report appears to have been seen by the court.

5.86 In the medical reports, non-compliance was given as a reason for the detention in just under 60 per cent of psychiatrists' reports and over 40 per cent of GPs' reports. Lack of insight was cited equally by psychiatrists and GPs in just under 40 per cent of cases. Risk to others was cited in just over 10 per cent of psychiatrists' reports and just over 20 per cent of GPs' reports. The figures for risk to self were just over 30 per cent of psychiatrists and a half of all GPs. These apparent gaps between psychiatrists' and GPs' assessments of their patients' behaviour were the widest of all the three courts. A quarter of reports consisted of 12 words or fewer and nearly half consisted of 12 to 20 words. Just under 40 per cent were illegible in part or in whole.

COURT C

PRACTICE AND PROCEDURE

5.87 Court C deals with cases from a large, predominantly rural, and in parts remote, area. Staff use desk procedures to administer applications which set out the relevant requirements of the Act and the necessary elements related to form filling. In general, processing an application for a section 18 order is regarded primarily as an administrative exercise, whereby if the relevant forms are correctly completed and there is no conflict between the doctors' opinions, then an order is made.

5.88 The tight time-scales within which applications must be heard causes significant difficulties in Court C. As in Court B, all other court business is put aside to deal with mental health applications but the disruption to general court business is felt more keenly and there is little room for flexibility for hearing dates within a large rural area where individuals are required to travel considerable distances to court.

5.89 The Sheriff Depute has attempted to overcome these practical problems by arranging a first calling on a Friday afternoon with an evidential hearing the following Friday. There is, however, resistance to this in the medical community since psychiatrists are not always available every Friday. In addition the sheriff clerk is attempting to persuade clinicians to make applications earlier – on the 16th day of the patient’s detention, and not on the 24th day as is commonly done. This would allow more time to set hearings, arrange representation and obtain second opinions.

5.90 When an application is made a nurse and the MRO in the local psychiatric hospital will explain court procedures with the patient. A list of legal representatives is pinned up in every ward in the hospital beside the telephone. Hearings are heard in a small court room or in chambers and are closed to the public. Three sheriffs hear mental health cases. No wigs or gowns are worn and all involved sit around a table in front of the dais. Witnesses still give evidence in the witness box. The case for the local authority is always presented by the local authority solicitor. If the application is unopposed, the solicitor will come in the MHO's place.

Number of orders

5.91 Court C dealt with 47 applications in this year, receiving, on average, one application each week. 2 applications were not granted.

Timescales

Number of days between date of application and expiry of current section

5.92 In nearly 40 per cent of cases, applications were made when there were still four days or less left before the section 26 order expired. In 38 per cent of cases, five to eight days remained of the order. This was the highest percentage of cases in this category in the three courts.

Table 5.28 Number of days between date of application and expiry of current section

	Number	% (N = 35)
Same day	1	3
1 day	1	3
2 days	4	11
3-4 days	8	23
5-6 days	10	29
7-8 days	3	9
9-10 days	2	6
11-13 days	0	0
14-21 days	1	3
22-28 days	1	3
29 days	1	3
Section expired before application made	1	3
Missing data	2	6
TOTAL	35	*100

*Percentages do not add up to 100 due to rounding

Number of days' notice given to patient of hearing

5.93 57 per cent of patients were given less than three days' notice of the hearing. 37 per cent of patients were given between three and six days' notice. No patients were informed of the hearing on the day of the hearing.

Table 5.29 Number of days' notice given to patient of hearing

	Number	% (N = 47)
Same day	0	0
1 day	16	34
2 days	11	23
3-4 days	13	28
5-6 days	4	9
7 days	0	0
Patient informed after the hearing	0	0
Missing data	3	6
TOTAL	47	100

Period of time between expiry of section 26 and decision

5.94 Table 5.30 sets out the number of days between the expiry of the section 26 and the decision by the court on the section 18 application. Although data are missing or are not relevant for 14 cases, the figures still show that in 30 per cent of cases (10) seven or more days had passed between the two events. There were continuations in 9 of these cases. However, it also shows that in 24 per cent of cases, the section 18 was granted before the section 26 had expired.

Table 5.30 Period of time between expiry of section 26 and decision

	Number	% (N = 33)
s18 granted before s26 expired	8	24
s18 granted on same day as s26 expired	1	3
1-2 days	5	15
3-4 days	7	21
5-6 days	2	6
7 days or more	10	30
TOTAL	33	*100
Missing data or not applicable	14	

*Percentages do not add up to 100 due to rounding

Legal representation

5.95 38 per cent of patients were legally represented. No curators ad litem were appointed and no advocates were used.

Patients' attendance at the hearing

5.96 Patients attended the hearing in just over a third of all the cases (34%).

Evidence

5.97 Evidence was given in only 23 per cent of cases. The patient gave evidence in 11 per cent of cases.

Continuations

5.98 There were no continuations in 68 per cent of cases. In 23 per cent of cases there was one continuation and in 9 per cent of cases there were two continuations.

Table 5.31 Number of continuations

	Number	% (N = 47)
None	32	68
1	11	23
2	4	9
TOTAL	47	100

Reasons for continuations

5.99 Only one continuation was granted to obtain a second psychiatric opinion and 2 to instruct a solicitor. No information is available for the other cases.

Table 5.32 Reasons for continuations

	Number	% (N = 15)
To instruct a solicitor	2	13
To obtain a second psychiatric opinion	1	7
Other reason	7	47
None given	5	33
TOTAL	15	100

Contested cases

5.100 In 23 per cent of cases, evidence was called. In only one case was a continuation granted in order to obtain a second psychiatric opinion and in 38 per cent of cases the patient was legally represented.

Decisions

5.101 The order was granted in 96 per cent of cases.

MEDICAL REPORTS

5.102 In most cases (89%) the doctor who saw the patient was their own GP.

Table 5.33 Status of doctor who saw patient

Status of Doctor who saw patient	Number	% (N = 47)
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Patient's GP	42	89
Not patient's GP	5	11
TOTAL	47	100

The Analysis of medical recommendations and reports

Non-compliance and lack of insight

5.103 Table 23 shows that in 19 per cent of cases the psychiatrist's report stated that the patient would not comply with the medication prescribed by doctors. In 28 per cent of cases the GP's report mentioned non-compliance.

Table 5.34 Non-compliance with medication

Non-compliance mentioned in medical reports	Number	% (N = 47)
Psychiatrist	9	19
GP or other doctor	13	28

5.104 Lack of insight was mentioned as a reason for the application (on its own) in none of the psychiatrists' reports and in only 4 per cent of GPs' reports.

Table 5.35 Lack of insight

Lack of insight mentioned in medical reports	Number	% (N = 47)
Psychiatrist	0	0
GP or other doctor	2	4

5.105 Both non-compliance and lack of insight were mentioned in 53 per cent of psychiatrists' reports and 38 per cent of GPs' reports.

Table 5.36 Non-compliance and lack of insight

Non-compliance and lack of insight mentioned in medical reports	Number	% (N = 47)
Psychiatrist	25	53
GP or other doctor	18	38

5.106 In total therefore, non-compliance was mentioned in 72 per cent of psychiatrists' reports and in 66 per cent of GPs' reports. Lack of insight was mentioned in 53 per cent of psychiatrists' reports and in 42 per cent of GPs' reports

Risk to others

5.107 In no cases did either the psychiatrists' reports or the GPs' reports state that the patient posed a risk only to other people.

Risk to self

5.108 The number of doctors citing patients' risk to themselves, though higher than the number said to be a risk to others, was still low: only 9 per cent of psychiatrists and 4 per cent of GPs.

Table 5.37 Risk to self

Risk to self mentioned in reports	Number	% (N = 47)
Psychiatrist	4	9
GP or other doctor	2	4

5.109 30 per cent of psychiatrists and 32 per cent of GPs stated that patients posed a risk both to others and to themselves.

Table 5.38 Risk to others and to self

Risk to others and to self mentioned in reports	Number	% (N = 47)
Psychiatrist	14	30
GP or other doctor	15	32

5.110 In total, risk to others was mentioned in 30 per cent of psychiatrists' reports and in 32 per cent of GPs' reports and risk to themselves was mentioned in 38 per cent of psychiatrists' reports and 36 per cent of GPs' reports.

The brevity of medical recommendations

5.111 34 per cent of medical reports consisted of 12 words or fewer and 13 per cent consisted of 12 to 20 words, a total of 47 per cent.

Table 5.39 How brief were medical recommendations?

Brevity of medical recommendations	Number	% (N = 47)
12 words or fewer	16	34
12 - 20 words	6	13
Not brief	25	53
TOTAL	47	100

The legibility of medical recommendations

5.112 19 per cent of cases included a medical recommendation that was illegible in part or in whole.

MHO AND OTHER REPORTS

5.113 In over half the cases (55%) the court had a separate MHO report to look at.

Table 5.40 Number of MHO and other reports

	Number	% (N = 47)
MHO report on Form 2 only	9	19
Separate MHO Report only	26	55
MHO + SCR	5	11
MHO + Psychiatrist's report	0	0
MHO + Psychiatrist's report + SCR	1	2
Missing data	6	13
TOTAL	47	100

APPEALS

- There were 13 appeals heard in Court C, six of them against section 30 orders and seven against section 26 orders. This was far higher than in the other two courts (2 appeals in Court A and one in Court B). Most of the people who appealed were in hospital when the appeal was made and the majority of the appellants were male (9 out of 13).
- Nine orders were appealed by males and four were appealed by females.
- In nine out of the 13 cases, the appellant was represented.
- In only 2 cases was the appeal granted. Both cases were s30 appeals.

SUMMARY

5.114 Court C is a court that deals mainly with applications from the surrounding urban area but also from a large, mainly rural, isolated hinterland. The court reported the greatest difficulties in administering cases, caused in part by the distances doctors are required to travel to attend court and to visit patients. However, despite these reported problems, in only 40 per cent of cases did the section 26 order have 4 days or less to expiry. This was lower than in the other two courts and Court C had the highest percentage of cases in which 5 to 8 days remained of the section 26 order. This perhaps indicated that the court was having more success in trying to encourage applications to be made earlier in the life of the section 26 order than it realised. Despite this, in just under 60 per cent of cases, the patient was given less than 3 days' notice of the hearing. In a third of cases the patient was informed of the hearing the day before.

5.115 As with Court B, about 40 per cent of patients were legally represented but no curators ad litem were appointed in Court C. A list of local solicitors was available on hospital wards and one solicitor in particular was actively involved in these applications. Patients attended the hearing in just over a third of cases, as in Court A, and oral evidence was called in just under a quarter of cases. Continuations were used in just under a third of cases but in only one case to obtain a second psychiatric opinion. Court C was distinguished by the relatively high number of appeals against both section 26 and section 30 orders.

5.116 In the medical reports, non-compliance with medication or treatment was cited in just under three-quarters of psychiatrists' reports and two-thirds of GPs' reports and lack of insight in just over a half of psychiatrists' reports and about 40 per cent of GPs' reports. Risk to others was cited in about 30 per cent of both doctors' reports and risk to others in 38 per cent of psychiatrists' reports and 36 per cent of GPs' reports. These were far higher figures than in either Courts A or B. About a third of doctors' reports consisted of 12 words or fewer and just under 20 per cent were illegible in part or in whole.

CHAPTER 6 EXPLANATIONS

INTRODUCTION

6.1 At the beginning of this research, there was very little information available about what happens when an application for a section 18 order is made to the court. The primary aim of this project was to provide basic information to fill this gap. Chapters 3, 4 and 5 have attempted to do this by presenting national data from the MWC database and the MHO survey and local data from the three case studies. These sections of the report go some way to explaining how this particular part of the Mental Health (Scotland) Act works; the purpose of this chapter is to provide explanations, where possible, for why it operates in this way.

6.2 The data it uses come from the interviews conducted between September and December 1999 with a range of people who had personal or professional experience of section 18 orders or detention under the Act. Although the interviewees were not representative, they do provide another perspective on the operation of the Act. In particular, they show how widely practice appears to vary across the country.

6.3 What emerged most strongly from the interviews was the perception that the section 18 process is, in most cases, split into two: part one takes place in the hospital and involves the patients and the medical staff who are trying to treat them; part two takes place in the court and involves sheriffs, clerks, solicitors and MHOs. In some cases, where evidence is called and the patient attends the hearing, the two parts are linked. But in most cases, the people most concerned with the outcome of the application, the patient and medical staff, play very little part in the court process and do not attend the hearing. MHOs are, in many cases, the link between the hospital and the court.

6.4 The split in the process was reflected, for the most part, in the interviews. Solicitors, sheriffs and clerks had the most to say about the court hearing and were the most preoccupied with court procedures, understandably so, as for them, this was the main focus of the whole process. For patients, doctors and carers however, what happened outside court was of considerably greater importance than the hearing, in which few of them played any part. MHOs, as their role would suggest, had more to say about the system as a whole.

6.5 This chapter is organised as follows:

- An analysis of case characteristics drawing on the MWC and MHO data and the case studies;
- An evaluation of the extent to which patients' interests are protected through the use of curators ad litem, independent medical or other evidence and appeals;
- An assessment of the extent to which patients and relatives avail themselves of their rights and a consideration of the barriers that exist to the uptake of these rights;
- An assessment of the extent to which patients are represented, by whom and whether in receipt of Legal Aid and the barriers to uptake and exercise of these rights.

1.14

CASE CHARACTERISTICS

6.6 Section 18 applications are characterised by:

- Tight statutory time-limits
- Informal hearings, sometimes held in non-court venues
- Mostly written evidence with few appearances by main witnesses
- Few unsuccessful applications
- Low levels of patient attendance
- Low levels of legal representation
- Low levels of participation by nearest relatives
- Few appeals

The first four of these characteristics are assessed here and the second four in the next section on patients' and relatives' rights.

Time limits

6.7 There are time-limits in the section 18 process and these can cause problems for the courts and court users. A prescribed five working days are available between submission of the application and the hearing.

The expiry of the section 26 order

6.8 If a patient is to be detained beyond the 28 days allowed by the section 26 order, either an application for a section 18 order or a report under section 26A to extend the section 26 by 3 working days¹¹ must be submitted before the section 26 order expires. Court C in particular complained about the short notice given to it to process these applications and suggested that if applications were made earlier in the life of the section 26 order, more time would be available to arrange a hearing that did not disrupt other court business. In fact, in Court C, more than half the applications were filed with five days or more remaining of the section 26, a higher percentage than in either Court A or B. Furthermore, the Act provides a period of 5 working days to hold the section 18 hearing, regardless of when in the 28 day period the application is initiated.

6.9 Several reasons were suggested in the interviews for the late filing of applications: poor communication within hospitals; doctors' lack of knowledge of procedures; and, in rural areas, the amount of time doctors spend at outlying clinics, which mean that they do not see patients in main psychiatric hospitals regularly enough.

¹¹ This appears to be rarely used judging by the case studies.

6.10 Patients also pointed to the complexities of the treatments given to them in hospitals and the way doctors use detention under section 26 and section 18 as part of a treatment regime. Once a patient is in hospital diagnosis of their illness and identifying an effective and viable treatment regime can take time. Patients suggested that modern drugs may take several weeks to take effect and they have to adapt to them. Different treatment regimes, which can be very complex, may be attempted until a solution is found.

6.11 The section 18 order allows the doctors more time for the treatment regime to become established. Psychiatrists reported that they often wait until the end of the section 26 order to see if the treatment will work or if the patient will comply with the treatment before requesting a section 18 order. Section 26A, which allows an a short additional period of detention under section 26, appears not to have been used very often in the case study courts.

6.12 Doctors appear to regard section 26 orders and section 18 orders as part of a rolling authority for detention that allows them to treat the patient over the course of several weeks or months. They perhaps do not give the procedural demands of a section 18 order the attention that others involved in the process think that they should.

6.13 This research was unable to find out how many potential section 18 applications are not made because of the need to comply with the procedural requirements and for the doctors' assessment to pass the scrutiny of the court. No mention was made of this in interviews; comment was only made on those detentions that do go on to be extended through the use of section 18.

6.14 One solution to the court's problems would be, as the clerk in Court C suggested, to apply for section 18 orders earlier in the life of the section 26 order – although the legislation would also need to be amended to remove the 5 day time limit for holding the hearing. The application could then be withdrawn if it was no longer required. This occurred in 9 cases in Court A, which may indicate that this practice is more widespread in that court. In Court B, the MRO reminds psychiatrists when a section 26 order is about to expire. However, psychiatrists in this area did not make their applications much earlier than in the other two courts which may indicate the limits of administrative influence over medical practice.

Making the application - MHOs

6.15 Doctors' decisions to make an application for a section 18 order had its greatest impact on MHOs, who were then required to make an assessment of the case before the section 26 order expired. Sometimes the MHO will have been involved with the patient when they first came into hospital which may give them more time to prepare the Form 2 for the court. But in many cases they are not involved at this stage and, as one MHO put it, the first thing they know about the case is when a blank application form with two medical recommendations is brought to them by the hospital porter. This can leave them with little time to complete a proper assessment.

6.16 In Court A, MHOs were said not to be informed of the application until late in the day, usually by fax after the psychiatrists have discussed the need for the order with the other hospital staff. It is also common practice in Court A for sheriffs to want background reports and they are not satisfied with just the Form 2. The MHO in this area described having to rush

around at the last minute to prepare a typed report - the court clerk will not allow reports to be filed late.

Preparing the case

6.17 Once the application has been submitted, the court and the parties have 5 working days before the case must be heard. For the patient, these 5 days are crucial if they wish to be represented and to participate in the application. Neither the Act nor the Sheriff Court Rules prescribe periods within which the patient must be told about the hearing. In theory, therefore, the patient could be told on the day. In practice this happened in 3 cases in Court A and in none of the cases in Courts B and C. The lack of adequate notice was a major complaint for solicitors who found they did not have time to provide what they regarded as proper representation for their clients.

6.18 This appeared to be a particular problem in Court C where in 34 per cent of cases, the RMO told the patient about the application the day before the hearing. (This happened in 20 per cent of cases in Court A and in only 7 per cent of cases in Court B.) This point was picked up by a solicitor working in the Court C area who suggested that psychiatrists do not always inform patients of hearings as quickly as they might. She questioned whether psychiatrists understand the significance of the notification form and the corresponding duty to give patients adequate notice of the hearing.

6.19 A continuation after the first hearing can give a solicitor more time to take instructions and to prepare the case. Interviewees suggested however, that in some areas patients are not treated during continuations and this would prolong the time before the treatment could start or recommence. Extra hearings also eat into court time and could be avoided if patients and solicitors had more time to prepare for the first hearing.

6.20 Time limits can be particularly problematic in rural areas where professionals have considerable distances to travel to see patients or to attend court.

Venue

6.21 Data about the importance of the venue for the hearing came from the interviews. All three case study courts attempted to make hearings as informal as possible and in Court B, hearings were usually held in the hospital rather than in the court itself. There was generally a split between those interviewees who wanted cases to be heard in court and those who would prefer them to be heard in other venues, especially hospitals.

6.22 Health professionals thought courts were inappropriate, particularly for patients and their relatives because they were intimidating, stressful and associated with criminal procedures¹². They also thought that adversarial hearings could damage the doctor-patient relationship. Psychiatrists were particularly supportive of holding hearings in hospitals, as it was more likely that patients would attend. It was also more convenient for them to have hearings there as it made fewer inroads into their already busy day and it gave them the opportunity to appear in the environment in which they felt most comfortable.

¹² Note there is plenty of evidence for this across the general public from a range of studies.

6.23 One of the sheriffs from Court B had a pragmatic reason for preferring hearings to be held in hospital, that is the ease with which GPs can attend the hearing and park. This was more important than it sounds as in his experience, GPs are generally unenthusiastic about attending court so anything that encouraged their attendance, was in his opinion, for the good.

6.24 None of the users who were interviewed wished to have hearings held in hospitals. All thought that the chance to appear before a sheriff in a court, even though it was intimidating, guaranteed them a fair and independent hearing. Courts were more popular with solicitors; in their view patients are happier with this and it is easier to question doctors' evidence outwith the hospital environment. Holding hearings in hospitals sustains what is already a medically dominated model of illness, even though it is easier for the patient to attend a hearing in a hospital. Also a court was regarded as the appropriate venue for the removal of someone's liberty. One solicitor felt that although hearings in court could be stressful for their patients, this was often due to not treating patients like adults and giving due regard to their wishes.

6.25 2 solicitors thought that hearings should be held in hospitals or other venues and one believed that the court should be replaced by a tribunal system similar to the Children's Hearing system, chaired by those with specialist knowledge and training in the law. These tribunals would sit in a variety of venues. He did not think psychiatrists should sit on the panel because he did not think they would be independent. MHOs thought hearings should be heard in a range of venues, including hospitals.

An alternative point of view

6.26 The views expressed by interviewees (especially patients) for this research about the venue for hearings were not mirrored by the responses to the consultation document issued by the Millan Committee in June 1999¹³. In all 202 responses were received by the Committee, from individuals and organisations. Service users and carers thought that the sheriff court treated people like criminals and that it was intimidating and too formal, views echoed by interviewees for this research. Overall, service users and carers wanted the sheriff court to be replaced by an alternative forum, such as a tribunal, which was regarded as being less intimidating and more humane. Some users said they would rather have the hearing in hospital than in the court-room.

6.27 The independence of the chosen forum for these applications does not appear to have featured as a concern in the Millan consultation responses. Users were more concerned with how they were treated by the court and how the court made them feel. These responses imply that if the forum for section 18 hearings were less intimidating, patients might be more likely to attend hearings, to seek legal advice and therefore to participate in the process. Neither this research, nor the Millan consultation used representative samples. Respondents were identified through the Research Advisory Group for the former and the latter relied on those people who chose to respond to the consultation document.

6.28 The responses are not necessarily contradictory. Between them they point to the need for a forum that encourages patients to participate in the process but which guarantees them a fair and independent hearing. Whether these two aims could be achieved by changes to sheriff

¹³Scottish Development Centre for Mental Health Services (2000) *Analysis of responses to consultation leaflet issued to users and carers* (see References)

court practice or procedures, or whether a new forum should be created, is a question that will need to be tackled in the future.

Written Evidence

Form

6.29 The basis for section 18 applications is the two medical reports written by a psychiatrist and the patient's GP. Solicitors expressed concerns about the nature of the written evidence before a sheriff when hearing a section 18 application. In many cases this is limited to the 2 medical reports and the MHO report written on the prescribed Forms 2 and 3. In some cases, an additional report will be provided by the MHO, which will give more information about the patient's background and life-style. This occurred in 45 per cent of cases in Court A where it seems, some sheriffs insist on a separate written report. In Court B in all but one case (98%) the only written report before the court was the MHO report on Form 2. In Court C, over half the cases (55%) involved a separate MHO report.

6.30 It appears from all the data that the quantity of written information before a sheriff is, in some cases, quite limited; solicitors expressed disquiet about this and the quality of the evidence, pointing out that this is not always based on first-hand knowledge of the patient. In one of the case study areas, solicitors reported that sheriffs had expressed concern about prescribed forms not being filled in properly and about the brevity of the reports they receive from doctors.

6.31 Two quite opposing views about medical evidence were provided by interviewees: solicitors thought the Forms 2 and 3 on which MHO and doctors' opinions are written should be amended to provide fuller explanations of the reasons for the detention. One solicitor commented that she would oppose applications on the grounds that the information in the medical report was insufficient to support detention. One psychiatrist, however, objected to being asked to provide more information about the reasons for the detention. It was his understanding that the sheriff is there to administer the section 18 order, not to question medical recommendations. His view seemed to be backed up by one sheriff who stated that he would only question medical evidence if two reports were clearly inconsistent with each other.

6.32 It was clear from court records in the 3 case study courts that there is considerable variation in the length and legibility of written material presented to the court. Between a quarter (Court B) and a third (Courts A and C) of medical reports contained 12 words or less and between a fifth (Courts A and C) and almost forty per cent (Court B) were in some part illegible to the research team.

Content

6.33 Comment was also made about the content of medical reports, which, it was said to too easily describe patients as being non-compliant with medication and lacking insight into their condition. However, in interviews patients reported that the need to try different drug treatments (already mentioned above in the context of time-limits) may destabilise a patient considerably and lead to reluctance to comply with medication. It is perhaps therefore inevitable that non-compliance will be cited as a reason for seeking the application. A solicitor considered it unacceptable for a person to be detained against their will on the basis of medical

reports consisting of a few lines that do not detail the exact nature of the person's illness and why they cannot be treated in the community. Doctors did not share these concerns. In part this can be explained by the different perspective taken by the two professions: solicitors spoke of detention in terms of loss of liberty whilst doctors talked about it as a means of obtaining effective treatment.

6.34 When looking at the case records, the researchers did note that doctors did not usually back up the assertion of non-compliance with evidence of this save to say, in appropriate cases, that the patient had not complied with treatments in the past. It is this lack of information rather than the content of the reports that perhaps raises the most questions about the quality of evidence on which these applications are based.

Risk to self and to others

6.35 One psychiatrist, in the Court C area, expressed concern that he felt obliged to present reports to the court that painted an unrealistic picture of the patient's usual behaviour, emphasising abnormal behaviour and using terms that would be easily recognised by a non-medical reader. The explanation given for writing such reports was the adversarial nature of hearings and the need, in the psychiatrist's opinion, to ensure that the order was granted so that the patient can be properly treated. The data from Court C seem to bear this out as risk was cited in many more cases in this court than in Courts B or A.

Oral evidence

1.15

6.36 From the MHO survey it appears that about half of section 18 applications are granted without any formal oral evidence being heard and half involve the MHO giving evidence to the court. What form this evidence takes is not known. However, from interviews it appears that the evidence given by MHOs as lay witnesses (in the sense that they are not medically qualified) is regarded more highly by some than others. The sense that they are likely to have a better knowledge of the patient than the patient's GP was certainly felt by one sheriff. In theory, if they have time, they can also provide information about the patients beyond their mental illness and their behaviour on the ward. This is especially the case where, as in Court A, they routinely prepare a Social Circumstances Report.

6.37 But there is also a sense amongst MHOs that they are marginalised in the process when lawyers are present in court and that this may undermine the value of their evidence (the MHO survey shows that MHOs are less likely to give evidence when the patient is represented). It is perhaps inevitable that there will be going to be a tension between the MHO who thinks they are doing their best by a client and the client's solicitor who thinks that they are also acting in the client's interests. This was most evident in Court A where representatives from both sides questioned each other's work.

6.38 Whilst patients only attended court in 28 per cent of cases, when they did they gave evidence in almost two-thirds of cases (64%). However, overall, patients gave evidence in only 18 per cent of cases. Representation did not automatically lead to the patient giving evidence: only 40 per cent of the patients who were represented gave evidence (see below for further discussion of this point).

6.39 Other witnesses rarely attend; in particular psychiatrists only give evidence in 18 per cent of cases and GPs in 13 per cent of cases. The former figure is the most telling statistic about the nature of section 18 hearings. The fact that the psychiatrist's evidence is the basis for the application makes them the most important witness. The fact that so few of them are called to give evidence indicates that there are few cases where the patient actively seeks to undermine the whole basis of their detention. One of the difficulties, identified in the interviews, was obtaining a second psychiatric opinion that would challenge the doctor's report. This is considered below.

GPs

6.40 The low level of attendance by GPs is indicative of their generally peripheral role in these proceedings. One sheriff expressed some reservations about calling GPs to give evidence because, he felt, they do not usually know the patient, especially if they work in a large practice. This is despite the fact that they will often initiate the detention process by notifying the hospital about the patient's problems.

6.41 One MHO expressed the view that many GPs have little experience or knowledge of mental health, especially section 18 orders. They are therefore unlikely to write anything substantially different from the psychiatrist on the Form 3. However, this could in some cases be put down to medical etiquette; GPs are generalists and, having referred a patient to an expert (a psychiatrist), will be guided by the expert's view.

6.42 The case studies show however, that this may not be the case. In Court A, psychiatrists and GPs agreed for the most part on whether the patients presented a risk to themselves or others and were fairly close on lack of insight and non-compliance. In Court B however, the two doctors differed quite substantially on assessment of both types of risk and over the subject of lack of insight. In Court C there were differences but these were only substantial on the patient's lack of insight into their illness. It would appear therefore that GPs do not follow psychiatrists as closely as some might think. It could also point to GPs not knowing what aspects of the patient's behaviour should be mentioned on the court forms.

1.16 Outcomes

6.43 One of the hardest pieces of information to obtain in this study was the number of applications that are unsuccessful. This proved remarkably difficult. The MWC only receives court papers for those applications that are granted, which meant the research team did not have the means to identify unsuccessful applications from a central source. The only way this information could have been collected would have been to gain access to the court records of every sheriff court in Scotland and to count the number of applications that were not granted.

6.44 Attempts were made to collect the data from court records. In Court A, for this year, four orders were not granted and nine were withdrawn. Of all applications then, 86 per cent were successful. In Court B there was only one unsuccessful application, which was dismissed by the sheriff. In Court C the order was not granted in 2 cases.

6.45 Given the low levels of attendance by patients, the low percentage of cases which are contested (according to the MHO data) and the fact that in only 18 per cent of cases are psychiatrists called to give evidence, it seems unlikely that many applications would fail. If the

prescribed forms had been correctly filled in, the doctors' reports appeared consistent and if the MHO agreed with the application, there would be no reason for the application to be refused.

6.46 It was not clear from case papers why cases were unsuccessful although in Court C one case had failed on a legal technicality: the patient's own GP had not examined the patient and a GP attached to the hospital had been used instead. The Act says that the patient's GP must be used, if 'practicable'. Solicitors had successfully argued that the hospitals have interpreted this as 'convenient' and the application has failed. Interviewees suggested that other cases had failed on the same grounds though the number is unknown.

PROTECTING PATIENTS' INTERESTS

6.47 Three measures were suggested in the research brief for protecting the patient's interests in section 18 proceedings: curators ad litem, second opinions and appeals. The latter applies not to section 18 applications but to renewals under section 30 as a section 18 order can only be appealed to the MWC and not to the court. As the MHO and case study data shows, all three measures appear to be used relatively rarely.

Curators ad litem

6.48 Curators ad litem were appointed in 24 per cent of cases and nearly half of these were appointed in one court. In the case studies, only Court B made any great use of curators ad litem and, as with legal representation generally, an appointment was made after consultation between the court and the hospital about what type of representation would best suit the patient. In 5 of these cases the patients had stated on the prescribed form that they did not wish to be represented.

6.49 It would appear therefore, that save in this court, sheriffs are not making great use of this discretion allowed by the Sheriff Court Rules. In interviews, solicitors stated that many solicitors avoid curator work because payment comes through Legal Aid and does not always cover their outgoings. Solicitors felt that the court should fund such appointments, as they do for reporters in Child Care cases. Some thought that more patients should be represented by curators ad litem, but the majority of interviewees felt that very few mentally ill patients are unable to express their wishes and therefore are capable of giving instructions to a solicitor. They do not need the services of a curator ad litem. To a certain extent, this view is supported by the MHOs' view that three-quarters of their clients were capable of expressing their wishes and feelings.

Second opinions

6.50 The importance of, and barriers to obtaining second psychiatric opinions were discussed in the case study interviews and it was said to be difficult to challenge an application without one. This can cost between £200 and £400 and it is difficult to obtain opinions from doctors who live far from the courts. The Scottish Legal Aid Board will not pay for the costs of travelling such distances making it difficult for solicitors to pay for such opinions in rural areas. One solicitor reported using retired consultants to write these reports if he could not find anyone available who was still working.

6.51 In Court A, second opinions were said to be easy to obtain and sheriffs were said to place a great deal of emphasis on them. In 49 per cent of cases there was at least one continuation and many of these were to obtain a second opinion, although only in a few cases did this evidence appear to be used in the final hearing. In Court B second opinions were also said to be relatively easy to obtain. Generally however, few second opinions are lodged with the court. In contrast, second opinions were said to be difficult to obtain in the Court C area and only one case was continued to obtain a second opinion.

6.52 In most cases, the hearing would be continued in order to obtain a second opinion. According to interviewees from two areas of the country, doctors (in their areas) are reluctant to treat patients during continuations so the impact of an application for a second opinion could affect the patient's immediate well-being. Continuations were not popular amongst medics - their priority is to treat the patient. However, there also seems to be a somewhat inaccurate perception amongst doctors that many cases have continuations and that these can extend the life of an application by many weeks. However, this appears not to be the case in all courts. In Courts B and C for example, there were no continuations in 79 per cent and 68 per cent of cases respectively.

6.53 The potential impact of continuations can be seen in Court A, which had the highest number of continuations generally and specifically, to obtain second opinions. In that court, 47 per cent of cases were completed 7 days or more after the section 26 order expired and 17 per cent of cases ended more than two weeks after the section 26 expired. The corresponding figures for Court B and Court C were far lower.

6.54 The evidence from the case studies would appear to show that the use of independent medical evidence has very little impact on the outcome of cases or on the protection of patients' rights. This is because the court sees so few of them, presumably because they support the original psychiatrist's medical recommendation. On the contrary, the process by which these opinions are obtained may have a negative impact on the patient, if, as some interviewees suggest, patients are not treated while the case is continued. As in many other areas of this research this part of the process threw up the tensions between the need to treat the patient and the need to ensure that their rights are protected by the legal process.

6.55 Seeking a second opinion may serve other purposes than challenging the medical evidence presented by the patient's doctors. In Court B, one solicitor found it worthwhile obtaining such a report to prove to patients that the detention was justified. Seeking the opinion may also be an end in itself if, regardless of its contents, it allows the patient some control over the process.

Appeals

6.56 In this year 2005 section 18 orders were renewed but only 30 were appealed - less than 2 per cent. Information on appeals against the renewal of orders and section 26 orders is held centrally by the Central Legal Office which acts for NHS Trusts in such cases. Data from MHOs on half the successful applications made during 1998/9 suggest that less than half of one per cent of orders are appealed, although this information should be treated with caution as MHOs may not have been aware of the appeal. In Courts B and A there were one and two appeals respectively. In Court C, six section 30 renewals and seven section 26 orders were appealed.

6.57 Again, the court case studies showed that appeals were not only rarely held but in almost all cases are unsuccessful. Of the 16 appeals found in the case study courts, only 2 (both in Court C) were successful, 13 were unsuccessful and one was withdrawn. As this sample shows, there is considerable variation in the level of appeals in different courts even if outcomes differ little. The high level in Court C was explained by an interviewee from the CLO as being due to a very active solicitor. Numbers are too small for any meaningful analysis by type of case.

6.58 A perspective on appeals was offered by the CLO solicitor who had experience of them on a national scale. Equal numbers of clients appeal against section 18 renewals and section 26 orders but the greatest number of appeals are against transfers to the State Hospital. In some courts a curator is always appointed in an appeal and this can delay the court process. Most appeals fail because they lack evidence to support the patient's argument that they need no longer be detained. Even though a patient may lose an appeal, they may still obtain some modification in the care programme. However, the solicitor felt that failure to succeed is often regarded as another blocked avenue for the patient and the experience may be unhelpful to them in the long-term.

6.59 It is not clear why so few renewals are appealed though this may be for the same reasons that section 18 applications are not contested (see below).

PROTECTING PATIENTS' AND NEAREST RELATIVES' RIGHTS

1.17 6.60 One of the aims of this research was to find out the extent to which patients and relatives avail themselves of their rights, including the right to appear in court, and what barriers may exist to prevent them from doing so. The data on this subject, along with the data on representation, legal aid, evidence and contesting cases are all elements of one picture that shows how patients and relatives participate in the section 18 process. The elements are therefore inextricably linked and the data should be considered as a whole.

1.18 Patients' attendance at court

6.61 The MHO study showed that just over a quarter (28 per cent) of patients attended court. The interviews offered ample evidence of the barriers that are perceived to prevent them from doing so.

6.62 Looking at the data provided by patients and doctors about the detention experience, especially the impact of treatment regimes (see above and Appendix 1), it is evident that some patients (maybe many of them) will not be well enough to contemplate attending court. This was confirmed by one interviewee who pointed out that lack of self-confidence and low self-esteem also prevented people from appearing in what is for most people an intimidating environment. The link between courts and criminal proceedings was also said to be uppermost in people's minds; in Court A, this was understandable as patients may have to wait outside the court alongside defendants in criminal trials.

6.63 One doctor felt that some patients might actually enjoy the chance for public display and so they should be deterred from attending court. An appearance by the patient could, it was felt, undermine their position and many would not be able to put their case anyway.

Solicitors suggested that the barriers lay in medical staff and MHOs preventing or blocking patients' access to legal advisors, who might suggest that they attend court. The patients' interviews suggest that at the time of the hearing many may be unaware of their legal rights and status which makes it unlikely that they will participate in the process at all. As the data on time limits has already suggested, in some cases patients are not given sufficient notice of the hearing to obtain the legal representation that might give them the confidence to attend court or to prepare themselves for the hearing.

6.64 In the majority of cases (81%) where the patient did not attend, MHOs said that this was because they did not wish to do so. It is impossible to comment on how many of these patients made this decision after considering their rights in this matter and how many were intimidated, uninformed or too ill to do so. Comments added to the questionnaire do suggest that some patients saw little point in opposing orders and attending court as they thought the decision was inevitable.

6.65 When patients do attend court, MHOs and solicitors reported that, in most cases, they are allowed to address the court if they wish to do so. However, sometimes there was a reluctance to hear or pay regard to what the patient has to say. If a patient appeared angry and noisy they would not be heard. In some courts the sheriffs positively encourage patients to speak and give their views while sheriffs in another court were said to be dismissive. One MHO reported that in her local (city) court, if the patient attends and is not represented, the sheriff will take on a role similar to that of a lay advocate. When they do speak in court, patients' main concerns were said by professionals to be general questions about their care, medication and its side effects and the likely length of their detention.

6.66 Surveys of other legal processes, such as evictions and Debtors Act matters, also point to low attendance by defendants in other civil cases, something which should be borne in mind when considering this data. Also, people who are detained under section 18 are generally very ill as interviews with users about the impact of medication shows.

Nearest Relatives

6.67 The MHO data suggest that nearest relatives have a very small part to play in section 18 proceedings. Although the majority of them (79%) discuss the case with the MHO, only 13 per cent of them attended meetings and 6 per cent of them attended court. Three made the application for the section 18 order and only 2 were said to have contested the application.

6.68 It was the impression of one sheriff that relatives are marginalised early on in the section 18 process and this was confirmed by some interviewees. One MHO reported that in her area, consultants are reluctant to share information about patients' medication with family members because of patient confidentiality. This, in turn, made relatives feel left out of the process. However, she also admitted that her MHO colleagues tend to adopt a protective role towards relatives and carers. They are protected from pressure to pursue their rights since they are considered to be under so much pressure already. In the same area, sheriffs were said to give considerable weight to relatives' views in court.

6.69 Representatives from a carers' group and a patients' support group thought that generally, relatives did not know a great deal about their rights. This view was confirmed by a solicitor who felt that relatives were not kept informed about what is happening to their family

members; they are in awe of doctors and consultants and were said to avoid dealing with them. He suggested that MHOs were often the main source of information for relatives but sometimes people were not able to pick up or understand what was being said to them. He thought relatives should be brought into the process earlier and have their role explained to them. This was the view of a MHO who suggested that, in his area, Responsible Medical Officers are aware that relatives have a role to play but tend not to involve them until the last minute. Some patients stated that their relatives had been misled about what was happening to them.

6.70 One hospital offered a taught course on detention for carers, particularly those whose relatives were detained for the first time. The course covered a range of topics including confidentiality, ward procedures, treatment, discharge and follow-up. Staff reported that the course increased carers' feelings of inclusion and confidence in their role. A carers' group leader confirmed that his members had benefited from the course.

6.71 The same leader felt that for most carers detention is a very difficult experience. Many are reluctant to agree to a detention order and would rather have the decision taken out of their hands by a professional. Their direct involvement in the detention of a partner or child usually has a permanent and negative effect on their relationship. Intervention can also come very late in the day when a crisis has occurred and there is little acknowledgement of how hard carers try to obtain help for a family member before they are hospitalised.

6.72 A different point of view about relatives' involvement was offered by a support group worker, who pointed out that many patients do not want to have any contact with their relatives, especially if they have been abused by them in the past.

6.73 Several interviewees felt that the definition of nearest relative should be modified to encompass a broader range of family and other relationships, partly to take account of the breakdown in family relationships and in cases where there is a lot of family conflict. In practice, however, one interviewee felt that little attention is paid to the legal definition and social work departments treat the person closest to the patient as the nearest relative.

REPRESENTATION

6.74 One of the aims of this research was to collect information on the extent to which patients are represented, by whom and whether in receipt of Legal Aid. The MHO data show that 39 per cent of patients were represented, almost all of them by solicitors (only 3 patients were represented by others). Of these, 48 patients were represented by a curator ad litem, leaving 152 who were represented by a solicitor acting on their instructions - that is, 29 per cent of the whole sample. 27 per cent of patients were legally aided and a further 37 per cent were thought (by MHOs) to be eligible for legal aid but they did not apply for it.

6.75 The MHO data relate to legal representation in court. The data from SLAB show that there were more intimations for legal aid in this year - 650 in all. These two figures (the MHO and the SLAB data) do not apply to the same population of cases and for many reasons the comparison might be completely erroneous. However, it may point to the fact that far more people seek legal advice than are represented in court, which is no different from other civil cases. Lawyers may well advise clients not to oppose the application, especially if it is not possible to obtain a second medical report that will support their case. Patients may decide

not to oppose the application for any number of reasons. What is of interest to this research is identifying how patients obtain legal advice and representation and the barriers that exist to deter them from doing so.

6.76 Much of the data on this subject apply equally to the barriers to patients attending court and contesting applications.

Obtaining advice

6.77 Nurses were identified by the greatest number of interviewees as the key providers of information to patients and their carers. Nursing staff reported spending extra time with first admissions who often found their situation particularly confusing. All MHOs stated that they provided information to patients about the legal process and their rights and many were said to be the only source of information for carers and nearest relatives. One MHO said that her colleagues were seeking to improve their information-gathering techniques alongside developing consumer information leaflets.

6.78 Some hospitals were said to have standard policies for informing patients about their rights. For example, in one, the MRO has a standard set of procedures that include giving patients a list of solicitors and a written protocol for the delivery of information. This is backed up by nurses telephoning solicitors if patients require it. In Court B, the MRO also takes responsibility for ensuring that patients who wish to have legal representation obtain it. 2 MHOs reported that medical staff in their local hospitals are very positive about ensuring that people know about their rights; one of the solicitors felt that apart from a handful of psychiatrists, most doctors acknowledge that legal rights are important.

6.79 Other interviewees considered the booklets published by SAMH and the Legal Services Agency (LSA) to be very helpful in informing patients. However, information provided by the MWC was said not always to be available to patients.

6.80 In one area considerable effort had gone into developing better information to patients about their medication, based on information from users about their interests and needs. It was felt by health staff that the information itself and its active dissemination and use by various staff had led to an increase in compliance rates, thus reducing the need for compulsory detention. A side effect was that nursing staff too had become better informed.

1.19

6.81 Three very different approaches were taken in the case study courts to providing legal representation. Court B exerted the greatest amount of control over legal representation while Courts A and C appeared to take a less active role in this matter although at the first hearing in Court A legal representation is discussed. In Court C it appeared that it was left to doctors to inform patients of their right to legal advice. The high percentage of patient representation in Court A, may have been due to the specialist legal advice representation service provided in that area.

Barriers to legal advice and representation

6.82 Although professionals felt that generally, medical staff and MHOs do try and assist people in obtaining advice and representation, these views were not universal and patients and support groups took a less positive view. The problems faced by patients in seeking or understanding advice about their rights were linked to patients' rights, in particular, their right to withhold consent to treatments. There were three main reasons suggested for patients not obtaining legal advice and representation:

I Professionals' lack of knowledge of patients' rights

6.83 In some hospitals medical and nursing staff were said not to be very well-informed about patients' right to advice and representation. One solicitor reported that practice varied across the hospitals in one city; some had very good procedures, others appeared to have none at all. Knowledge of consent procedures among doctors was described as patchy by one MHO in another area; suggested that nursing staff may have a better understanding of them. Patients expressed concern generally about consent procedures when a patient is detained. They stated that consent for one treatment was sometimes interpreted by medical staff as a blanket consent for all treatments. Some nursing staff and medical staff were said not fully to understand or accept the right of patients to withdraw consent.

6.84 In some cases, however, newly-qualified medical staff may defer to MHOs on the issue of consent and MHOs are used by psychiatrists to give consent to treatment rather than nearest relatives (this was confirmed by a psychiatrist).

II Patients' lack of knowledge of their rights

6.85 While some interviewees thought that patients were knowledgeable about their rights, others suggested that many knew very little. A nurse expressed how shocked she and her colleagues had been to discover that many of their patients knew very little about the detention process and their rights. This group included patients who had been in and out of hospital over many years. As a result the hospital set up a course to inform patients and their families about these matters. Some patients reported that they only realised they were under compulsory detention when they tried to leave and that they had become aware of their legal situation through contact with support and advocacy groups. Views amongst support group representatives were mixed: members of one group were said to be well-informed about their rights, although medical staff do not make enough effort to inform them. Members of other groups were said not to be. However, it was pointed out by one interviewee that many patients had no desire to engage in the court and legal process, which would go some way to explaining the number of patients in the MHO survey who chose not to seek Legal Aid or representation.

III Other barriers

6.86 Some patients reported being detained unlawfully by hospital staff, feeling powerless to enforce their rights or opinions and of being threatened with compulsory detention if they did not comply with their treatment regime or expressed a desire to return home. Other threats, of withdrawal of clothing and access to consultants, had been used by nursing staff to persuade them to take medication. Several said that they had approached the MWC about unlawful detention but felt that the Commission did not accept that this was occurring.

6.87 Medical staff reported that providing information on the court process (as they are obliged to do under Rules of Court) could be particularly problematic where patients had limited understanding of their condition, making it difficult to tell whether patients wished to attend the court hearing or be legally represented. Some patients are too ill and distressed to absorb or understand the information provided. Over the 28-day detention treatment regimes are being assessed and this may also destabilise them.

6.88 Lawyers reported that patients might be fearful of contacting a solicitor and felt that they could easily be persuaded not to do so by nursing staff. This was confirmed by patients who felt that attempting to seek legal advice was seen as being troublesome and might increase the chances of compulsory orders and continued hospitalisation. In interview, most patients said that they had not taken legal advice even when aware of the need for legal representation or their right to challenge orders. Some had contacted the MWC but had not found this useful.

6.89 In Court C one solicitor was not convinced that hospital staff try very hard to arrange legal representation for their patients and may give up if a solicitor does not respond to their call immediately. He thought doctors do not like lawyers coming into hospitals and knowledge of the Act is generally poor amongst GPs. Concern was also expressed that the information recorded on Form 3 (stating that an RMO has informed the patient) is inaccurate (although it was not clear how a solicitor would know about this). However, according to the case study data as many patients were represented in this court as in Court B. This is also, despite the fact that a third of patients in Court C were informed of the hearing only the day before.

6.90 When patients did choose to be legally advised, lawyers reported that they frequently had 48 hours or less to receive instructions, see patients and prepare the case. This is confirmed by the case studies, especially Court C. Solicitors identified the following barriers to obtaining legal advice and representation: people do not know that they are entitled to legal representation or view solicitors as intimidating and costly; those with mental illness are more fearful than most about contacting solicitors and are more easily dissuaded from doing so; people who have been detained many times may find it difficult to communicate their wishes (though this was not backed up by the MHO survey); cultural attitudes among some ethnic communities hamper take-up of legal advice; lack of access to legal aid.

6.91 The Law Society does not recognise mental health work as a specialist area of practice so very few lawyers are expert in this field. One solicitor felt that lawyers should have training that would enable them to question medical definitions such as 'delusions', 'self-harm' and 'rationality'.

Lay advocates

6.92 Many interviewees felt that there was a greater role to be played by lay advocates both within and outwith the court process. A recurring comment in several interviews was that even though nursing staff might be willing and qualified to inform patients about their rights, many of them did not have enough time to do so. It was suggested that lay advocates would be able to do this.

6.93 One solicitor expressed the opinion that a lot of people do not want to approach a solicitor so a lay advocate can take the role of informing patients and relatives of their rights including their right to legal representation in court. The use of lay advocates also avoids putting the patient/nurse relationship at risk. In court, an advocate may be able to express the patient's feelings to the court. However, this takes time and sometimes psychiatrists involve the advocate very late in the day so that they do not have adequate time to get to know the patient and understand what they wish to say. In the advocacy group's opinion, few health professionals, solicitors or sheriffs understand the advocate's role. However, 3 of the solicitors interviewed thought advocates had a clear role to play in the section 18 process.

Conclusion

6.94 The interview data suggests that take-up of legal representation is dependent on several different factors: on the existence of procedures within hospitals to ensure that people are informed about their rights; on professionals within the hospitals having the knowledge themselves; on patients' ability or willingness to absorb and act upon the advice given to them; and access to leaflets and other sources of information from organisations such as SAMH. As the MHO survey shows, the apparent result of these factors is a wide variation in the take-up of legal representation across the country (see page 36).

PARTICIPATION AND CONSENT

6.95 All the measures considered above - giving and calling evidence, attending court, instructing a solicitor, are indicators of the patient's participation in the section 18 process. The MHO data provide several different measures of this participation: 27 per cent of patients were said to have contested the application, 28 per cent of patients attended the hearing, 27 per cent were legally aided and 39 per cent were represented, although 10 per cent of these were represented by a curator ad litem.

6.96 Understanding the links between all these indicators of participation is difficult and particular care needs to be taken in trying to make such links across the MHO data and the case study data. However, the analysis (pages 35-39) does seem to show that legal representation may encourage other forms of participation, although in a significant number of cases, patients were legally represented but did not play any other part in the case. Only a quarter of the patients who attended court were not represented. Conversely, a significant percentage of patients (43 percent) who had representation did not attend court themselves. Some of this group may have been represented by curators ad litem, they may have been too unwell to attend court and some may have wanted a solicitor to represent their interests in court for them. So although legal representation did not automatically bring the patient into court, it does appear that it was unlikely that the patient would appear before the court without the presumed support of a representative. This is unsurprising as the interview data confirm how intimidating the court is for many patients (as it is for many patients in other groups).

6.97 The MHO survey analysis also shows that in 80 per cent of the cases where the patient gave evidence they were represented. However, many (63%) of the 203 patients who were

represented did not go into the witness box. So again, representation did not automatically trigger further participation but without it, the patient was unlikely to participate in this way.

6.98 According to the MHO data, cases were far more likely to be contested if the patient was represented. Of the 140 contested cases, the patient was represented in nearly 90 per cent of them. Only 15 non-represented patients contested their case. The psychiatrist was also more likely to be called if the patient was represented.

6.99 The case studies confirm the gap between representation and attendance (although in Court B, notes on the file indicate that in many cases the patient may have had a solicitor appointed for them but the solicitor may not have attended court if the case was uncontested). In Court A at least a half of all patients were represented and at least a third attended court¹⁴. In Court B 38 per cent of patients were represented and it seems probable that, at most, just under a quarter attended court. (In Court B 18 per cent of patients were represented by a curator ad litem, leaving about 20 per cent of patients who were represented by a solicitor acting on their instructions). In Court C again 38 per cent of patients were represented and a third of patients attended court. In all three courts, therefore, more patients were represented than attended court.

6.100 In the case studies, the gap between representation and giving evidence was widest in Court A, where nearly half the patients were represented but only 9 per cent of them gave evidence. In Courts B and C the corresponding figures were 38 per cent and 11 per cent. It is not possible to explain the gap between representation and giving evidence in Court A though it may be due to the Form 2 (which is supposed to record whether evidence was heard) not being filled in properly.

6.101 All the above data show that patients participate in the section 18 process to many different degrees and the links between the different forms of participation are complex. Any attempt to encourage greater participation would have to untangle the processes by which patients gain access to information, how professionals provide this information, how patients obtain legal advice and representation and what leads them to decide to attend court and to give evidence.

6.102 In this respect, section 18 cases are no different from any other civil cases where research has shown that the decision to involve oneself in the legal process is equally complex. Clearly, however, mentally ill patients detained in a hospital face particular hurdles that other civil litigation participants do not and some specific elements have to be in place before a patient can participate in the process. In particular proper information about rights has to be available and accessible in a form that a patient can understand, the patient has to be well enough to participate, lawyers with adequate knowledge and experience must be available and patients must have enough notice of the application to enable them to take legal advice and prepare for the hearing. They also need access to legal aid, although this will be less of a problem now that this is no longer means-tested.

6.103 Even if a patient is able to participate to any degree, there is no evidence from the data in this research (which is, as already stated, limited by lack of information about unsuccessful applications) that legal representation has any impact on the outcome of applications - nearly

¹⁴ Data were missing for some cases

all the applications in the case study courts were granted. Also representation does not automatically trigger attendance at court or the patient giving evidence. It is possible that there is a core of assertive patients who would insist on being present at court, on giving evidence or on having evidence called with or without representation.

6.104 Evidence from the case studies suggests that the main impact of legal representation seems to be an increased use of continuations and the lengthening of the overall time-scale of the case. If, as the interviews suggest, doctors are reluctant to treat clients during continuations, the impact of legal representation on the client may be less positive than it first appears, particularly as so few second opinions appear to be used to support the patient's case. However, it is for the patient to judge whether participation of any type, from legal representation to attending court is worthwhile, regardless of the outcome of the case. The sense of powerlessness expressed by patients in interviews may be alleviated by such participation. What is clear, however, is that the patient cannot make such a judgement (assuming they are well enough) unless they have access to the proper advice and adequate time in which to assimilate it.

Duration of section 18 orders

6.105 One of the arguments put by solicitors and psychiatrists was that patients do not contest applications because they know they will not be in hospital for very long. Psychiatrists confirmed that section 18 orders were not often sought to ensure the patient remained in hospital for the full six month period. Rather, patients usually left hospital on leave of absence shortly after the section 18 order was made and most orders would be discharged within six months if the patient complied with the treatment and/or the treatment began to have an impact. In effect, psychiatrists used section 18 orders to fashion the equivalent of a Community Treatment Order allowing them the freedom and time they need to treat the individual as they judge.

6.106 Data held by the MWC on the 931 cases discharged between April 1998 and August 1999¹⁵ show that 57 per cent of the orders were discharged while the patient was on leave of absence and 52 per cent of the orders (485) lasted 6 months or less. The average duration of these 485 cases was 4 months. However, a quarter of the orders were discharged between 7 and 18 months after they were granted and the remaining quarter of patients remained on the order for more than 18 months. So, to some extent, patients are right in their belief that many of them will not spend a full 6 months in hospital. However, a substantial group may find themselves either in hospital or liable to be brought back into hospital for up to 18 months or more.

6.107 The MWC data on renewals underlines this point¹⁶. In 1998/9 there were 2005 renewals of section 18 detention orders for 1548 clients. A fifth were therefore duplicate renewals. A third of the clients whose orders were renewed had started the current period of detention during the same year, but 20 per cent had begun their detention between 1990 and 1995 and another third in 1996/7.

¹⁵ Note that these data do not relate to the same sample as MWC data on orders and renewals.

¹⁶ Again, it should be noted that these data do not refer to the same samples and so should only be regarded as snapshot data.

6.108 Clearly, there are clients who spend very long periods indeed under compulsory orders and are detained in hospital for long periods to ensure that they comply with treatment regimes. As the three samples are not comparable it has not been possible to case-track these clients. Such an exercise would produce valuable information on the extent to which renewals are generally used and how.

OTHER ISSUES

6.109 Three other issues were raised during the interviews which merit some attention. These were the role of the sheriff, the role of the MHO and the particular problems of rural areas.

SHERIFFS

6.110 Most sheriffs who heard mental health cases were said to be knowledgeable about the Act but there was some concern about lack of knowledge amongst some sheriffs and the length of some hearings. In one court cases are sometimes added to a sheriff's list late in the day and hearings may last only 10 minutes. In some courts, if the client is not represented, the sheriff will take on an advocacy role. Sheriffs were said to accept medical opinion too readily and are sometimes unwilling to listen to arguments disputing this.

6.111 Solicitors felt that sheriffs should be trained in mental health legislation and some solicitors thought designated sheriffs would improve matters. However, others pointed out that the outcome depended more on the identity of the sheriff than their expertise. One of the problems encountered by sheriffs in doing mental health cases is that few of them have experience of mental health work in their practice as lawyers.

THE ROLE OF THE MHO

6.112 MHOs felt that their status in detention cases was uncertain and their job difficult to perform. Their role in the process is to tell the court whether they support the decision to detain and, if they do not, they can express their non-support on the application form and are entitled to be heard. In practice, very few were said to do this. This is due to the difficulty of challenging medical opinion when they are not themselves medically qualified. One MHO gave the example of a case where he had thought the psychiatrist's decision was draconian but he did not feel qualified to oppose the application on this ground. If an MHO does oppose the application they will have to justify their decision in court which is a daunting prospect. It was suggested that perhaps MHOs should have a third option on the Form 2 that allows them to express their ambivalence about the application rather than forcing them to make an outright challenge to the doctors.

6.113 Conversely, MHOs can sometimes persuade psychiatrists not to make the application; examples were given in the interviews where this had happened. Much may depend on the relationship between the doctor and MHO and the doctor's assessment of the MHO's judgement. However, in some parts of the country the tensions inherent in the MHO's role of judging the doctor's decision to detain has led to tension between MHOs and health professionals.

6.114 MHOs felt their role should be clarified to address the demands of the court and more consideration be given to the value of non-medical assessment of a client's well-being. One user group representative felt that although MHOs try to be independent, they are still regarded by her members as being part of the medical establishment. An MHO stated that he had on occasions dissuaded a psychiatrist from pursuing an application because a patient's health had improved. There is a difficult role, according to one solicitor, because as a social worker they are meant to support their client, but as MHOs they are passing judgement on the client's mental health when they give their agreement to the application.

RURAL AREAS

6.115 Obtaining legal representation in rural areas is difficult for those with mental illness. In island communities, solicitors attend from the mainland and this is not always acceptable to local communities. Solicitors were of the view that detention is sometimes used in the Highland area because of a lack of alternative community provision for people.

6.116 Other problems are caused by living in isolated communities: the lack of choice of a GP, lack of support services; meeting places and day-time activities that would aid recovery. Relationships between a user and a health professional can become particularly close. This can make it difficult to voice concerns about care or treatment as there are few people available to speak to and criticisms can become personalised. In island communities, one user group representative felt that there seemed to be a lack of professional understanding of mental health issues and a problem with confidentiality amongst small communities.

6.117 However, it should be noted that the taboos about mental illness experienced in the Highlands were mentioned equally in Glasgow, as were the problems associated with complaining about individual professionals.

EQUALITY ISSUES

6.118 Very few significant differences were recorded between the data relating to men and women. A very small number of patients from ethnic minority backgrounds were picked up by the research but these were too small to be significant. Further research is to be commissioned to find out more about the experiences of this group.

2. CHAPTER 7 CONCLUSIONS AND SUGGESTIONS

2.1

2.2 Introduction

7.1 The aim of this research was to understand how section 18 orders operate in the sheriff court, to complement information collected by the MWC and to inform the work of the Millan Committee. The researchers were asked to find out a range of information about various aspects of the Act relating to the court process and patients' and relatives' participation in the process. Because of the lack of data about the Act several research methods had to be used to try and get hold of this information and none of them was entirely successful. However, stitched together, they do provide a perspective on what happens when a section 18 application is made, who is involved and what factors affect the extent of their participation.

7.2 This chapter attempts to fulfil the final aim of the research brief, which was to evaluate the extent to which the Act operates in accordance with the requirements of a modern legislative framework; for example, to assess the extent to which it is independent, effective and appropriate. These criteria are considered below from two points of view: whether the process as it is designed meets these criteria and whether it is able to meet them in practice.

Is the system independent?

7.3 There was no suggestion in any of the interviews that the sheriff court does not act independently of the parties involved in these hearings. The sheriff court was the preferred venue for patients and some solicitors because of its perceived independence from doctors and the medical environment. Only one interviewee thought a tribunal might do a better job. Whilst interviewees varied in their choice of venue, sheriffs themselves were not perceived as being a problem although some of them, it was suggested, could benefit from more training in mental health law and procedure and show more sensitivity towards patients' problems.

7.4 The section 18 application process offers 3 potential opportunities for independent scrutiny of the doctors' decision to detain a patient: the MHO's report, in which they can choose to support or oppose the application; independent psychiatric opinions; and, the sheriff's scrutiny of the evidence. In practice, MHOs often do not appear to take an independent stance on the application, although this may simply be because they agree with the doctor. However, in some cases MHOs are reluctant to oppose doctors' decisions and their non-medical perspective on the patient's illness is not always as valued as it might be. Independent opinions appear not to be seen by the court very often, presumably because they support the first psychiatrist's opinion. In some courts, such as Court C, they are rarely sought in the first place, due, it appears, to the lack of available consultants.

7.5 This research was unable to tell how much scrutiny sheriffs give to the court forms that come before them. Most cases are not contested and patients are not usually in court. Psychiatrists in particular rarely attend the hearings so the sheriff is, in most cases, left with only the Forms 2 and 3 and the MHO who, in most cases is supporting the application. As one sheriff pointed out, in the absence of any opposition from the patient, if the forms appear to have been properly completed then the application has to be made.

7.6 Should more scrutiny of the evidence be encouraged? It is difficult to see how this could happen under the present system. Nearly all the patients who are detained under section

18 are already in hospital when the application is made. In that respect, sheriffs are not being asked to make the crucial decision that would result in the patient's loss of liberty. If they were (and section 18 orders were supposed to be used to detain people from the community) there might be more hearings and lengthier scrutiny of the medical evidence.

7.7 Appeals against section 18 orders would introduce another element of independent scrutiny into the process. At present, patients can only appeal their detention to the MWC and in this year none of these appeals was successful. Only renewals can be appealed to the court and these, as we have seen, are rare.

7.8 The section 18 process as designed, therefore, does offer opportunities for independent scrutiny, though in practice they do not operate as effectively as they might due to factors, which are for the most part, beyond the control or remit of the court.

7.9 As mentioned in the last chapter, the conclusions of the Millan Committee consultation exercise were quite different from the responses to this research and indicated a preference amongst patients and carers for an alternative to the sheriff court. However, any alternative would have to ensure that it offers the independent scrutiny that appears to be lacking in the present system, as well as the more participatory form of justice that patients and carers would like.

Is the system effective?

7.10 Any measure of the effectiveness of the section 18 process is dependent on the stance from which it is viewed. From the doctor's point of view, whose priority is the treatment of the patient, the process is very effective, in that, as far as we can tell, most applications are granted. This allows them to treat the patient as they judge appropriate. From a procedural point of view, as shown in the case studies, the courts for the most part are operating the Act effectively, although as we have seen in Court C, this is sometimes difficult.

7.11 Where the process's effectiveness is more debatable is from the point of view of its ability to provide a forum in which the conflicting rights to treatment and liberty are adjudicated. Part of this is due to the process which does not prescribe how much notice should be given to patients of the hearing, which may hinder them in their attempts to obtain proper representation. This is exacerbated by the fact that it is the responsibility of the RMO to inform the patient of the hearing; as the interviews indicate, doctors do not always give their patients as much notice as they could. This was particularly evident in Court C.

7.12 Other measures of the process's effectiveness as a judicial forum have already been mentioned above under the heading of independence. Ensuring that the process works as it is designed to and providing patients with a fair hearing are all affected by factors outside the control of the court. These include access to information about rights for patients and relatives, professionals' knowledge and willingness to inform patients of these rights, the lack of legal expertise and a patient's capacity to participate in the process.

7.13 Doctors' willingness to play their part in ensuring the system's effectiveness is also a factor that Courts B and C showed was beyond the control of even the most efficient administrators. However, the one point at which the process may (according to interviewees in 2 parts of the country) interfere with the doctor's ability to treat the patient, when the case is

continued. If applications were made earlier in the life of the section 26 order then fewer continuations might be needed, and this would avoid the problem.

Is the system appropriate/accountable?

7.14 That the sheriff court (wherever its venue) is the appropriate forum for these cases was not much challenged in the interviews conducted for this research. Beyond this, the appropriateness of the process depends, as with effectiveness, on the perspective from which it is viewed. From the treatment perspective, one psychiatrist questioned the sheriff's rights to ask for more information about the proposed treatment; we do not know how widespread this view is. From the rights perspective, the process allows the doctor's decision to be challenged, even if in practice this rarely happens.

7.15 Another measure against which to judge the section 18 process is not appropriateness, but accountability. The figures quoted at the very beginning of this report highlight how small a percentage of patients are subject to section 18 detention. The majority of them are, for the most part, detained either voluntarily or under emergency and 28-day orders that do not require the scrutiny of the court. Patients detained under section 18 are therefore the exception and there are other aspects of the detention process that would merit more attention if numbers were the deciding factor. However, we also know that most patients who are detained under section 18 have already been detained under other provisions of the Act both immediately before the section 18 detention and in the past. Many will probably be detained again in the future.

7.16 The mental health system appears from this research as a continuum with some patients going in and out of hospital, sometimes over long periods of time. The MHA provides protection for their interests through the MWC, including the right to appeal a section 18 detention. However, the MWC does not conduct hearings in the way that the court does and this is perhaps where the importance of the section 18 process lies. It is the only point in the detention process where the decisions made about patient's treatment and their rights to liberty are debated in a semi-public, non-medical-dominated arena. While it is clearly important to individual patients to have their cases properly adjudicated, the section 18 process has perhaps a greater importance to the system as a whole, in that it can, in theory at least, subject doctors' decisions to an independent scrutiny that they might not otherwise receive. Doctors have to be accountable to their own professional codes of conduct and bodies but the section 18 process, as designed, does offer the chance, through individual cases, to scrutinise how doctors exercise their powers over very vulnerable members of the community.

7.17 Does the section 18 process achieve this level of accountability? Judged on the number of psychiatrists and GPs who attend court, the answer is probably no. Judged on the number of cases that are contested, where patients are represented and the patient attends, then again possibly not. It seems likely that few applications fail. This may indicate that cases are not given rigorous scrutiny, though this is hardly surprising as so few cases seem to be contested. However, the outcome of the case is less important than the process of scrutiny itself. Doctors may well be detaining people appropriately under section 18 but it is important, from a legal rights perspective, that those decisions are not taken arbitrarily but fairly and based on proper grounds.

7.18 It was suggested during the course of this research that sheriffs do scrutinise applications and we do not know enough about what goes on informally in these hearings or the discussions that are held between the hospital and the court before the application is granted. However, it is important that the process is seen to be accountable and, judged on the data presented in this study, this may not be happening in all cases. Informality was regarded as a positive feature of mental health proceedings. But it is more difficult to guarantee the protection of rights through the adherence to rules of evidence and procedure in an informal forum. Several solicitors commented on how lax were the rules of evidence in these cases and, from a legal perspective, although informality may make it easier for the patient to participate, it may not guarantee them a fair hearing.

7.19 It would be interesting to find out more about how these cases are scrutinised in those courts where legal representation, patient attendance and the hearing of oral evidence is the norm and to compare these with those courts where these rarely take place. It is likely that the outcomes are the same. It would be valuable however, to assess the impact of these different approaches on patients' perception of the fairness of the process and on the way doctors presented their case or took the decision to apply for the section 18 order.

Information and monitoring

7.20 The final measure of the section 18 process is the way the process is recorded by the courts. The biggest problem faced by this research was gaining access to very basic information about the court process. This turned out to be a remarkably difficult and time-consuming activity that was only able to provide partial answers to the questions raised. The fact that section 18 orders are not appealed in the courts may account for the lack of information recorded by the courts and possibly the haphazard way in which cases were recorded (in Court A in particular). However, the lack of accessible information is commonplace across the whole civil legal system and in this respect, mental health cases are no different from any other civil cases.

7.21 Information provides a means of measuring whether a process is independent, effective, appropriate and accountable. It can be used to pick up areas of good and bad practice and to ensure that the process as a whole is under scrutiny. At present, this is not possible.

Conclusion

7.22 The section 18 process, as designed, has the potential to be independent, effective, appropriate and accountable. How successfully it achieves this is dependent on whether precedence is given to the need to treat patients or the need to protect their legal rights. At present, it is more successful from the former point of view (save for the problems caused by continuations) than the latter. The provisions within the process that protect patients' rights, such as access to information and legal representation, do not work as effectively as they might due in the most part to factors beyond the control of the courts. Which viewpoint is the correct one is for others to decide but with the enactment of the Human Rights Act in Scotland, the need to pay greater attention to the protection of patients' rights is likely to become more pressing. With this in mind, this report ends with a list of suggested changes to practice and procedure in the sheriff court that might do more to balance the need to provide patients with effective treatment but with due regard for their human rights.

SUGGESTIONS FOR CHANGE

- The present 5-day period between submission of application and the hearing be extended to allow more time for cases to be prepared, witnesses organised and second opinions sought.
- The Act of Sederunt Court Rules be amended to prescribe that patients be given at least 3 day's notice of the hearing.
- Form 3 or its equivalent to be expanded to allow more information about the patient's illness and treatment options, and doctors to be encouraged to provide more information.
- Doctors' reports to be typed.
- In hospitals where one is not already assigned, a dedicated administrator be identified to liaise with the court over the administration of section 18 applications.
- The Law Society to recognise mental health law as a specialist area of work and to provide training for practitioners.
- The definition of the nearest relative be amended to take into consideration the complex nature of modern relationships.
- Courses for carers, covering consent, treatment, confidentiality and after-care be organised, such as the one at Queen Margaret's Hospital in Fife.
- Consideration given to encourage the funding and use of lay advocates both in hospitals and the courts.
- National protocols to be established on how voluntary and compulsorily detained patients are to be informed about their rights and by whom.

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APPENDIX 1

EXPERIENCES OF DETENTION

Introduction

In their interviews, patients, carers and doctors had a great deal to say about the experience of detention generally, rather than section 18 orders. These data are presented in this appendix to provide a context for the rest of the report. They cover patients' perspective on being detained, patients' experience of treatment and doctors' perspective on how they use the Act to treat patients.

Patients' experiences

Interviewees reported that hospitalisation and detention occur when a crisis point is reached. Obtaining support and help before this was said to be difficult. Patients reported they were usually aware that they were becoming unwell and needed help, but it could be difficult to obtain. In both rural and urban areas there were said to be few community-based alternatives and 24 hour support could be difficult to obtain. Carers were sometimes reluctant to sign a detention order; they wanted it to be handled by a professional as they were concerned that if they were to do this it might permanently affect their relationship with the patient. Data from the MHO survey support this – only three applications came from family members. Nearest relatives and carers also reported attempting to seek help for some time before the patient was hospitalised.

Patients and carers in rural areas experienced particular problems. Mental health problems were said to be more visible in smaller communities and support services could be difficult to access. Mental health problems were often regarded negatively. All these factors could prevent patients from seeking help and could hinder their reintegration and recovery following hospitalisation. Confidentiality and privacy could be hard to protect. Hospitalised patients in rural and remote areas were often based a long way from family and community support and felt isolated. This added to the stress of being in hospital.

MHOs reported that running effective out-of-hours services in rural areas could be problematic and central contact points meant that essential local knowledge was lost. Some interviewees suggested that the use of detention might be greater in rural areas because of the lack of alternative community provision.

Entering hospital was both a distressing and stressful experience, particularly the first time. Patients, carers, lawyers and nursing staff all reported that many patients were not aware of their legal status or rights. Some patients reported that they only realised they were under compulsory detention when they tried to leave and that they had become aware of their legal situation through contact with support and advocacy groups. Others reported being detained unlawfully by hospital staff and feeling powerless to enforce their rights or opinions. Patients who had entered hospital voluntarily spoke of threats of compulsory detention if they did not comply with their treatment regime or expressed a desire to return home. Other threats, of withdrawal of clothing and access to consultants, had been used by nursing staff to persuade them to take medication. Several said that they had approached the Mental Welfare Commission about unlawful detention but felt that the Commission did not accept that this was occurring.

Some nursing staff considered that the patients' lack of awareness could make it easier to detain them without a compulsory order. Lawyers reported that patients might be fearful of contacting a solicitor for various reasons and felt that they could easily be persuaded not to do so by nursing staff.

In rural areas there was little choice of practitioner or specialist, making it more difficult to exercise any choice of professional and inhibiting complaints and refusals. Lack of resources reduced the ability to prevent detentions as well as leading to patients spending longer time in hospital and slower reintegration and recovery times.

Patients were acutely aware of power relationships in hospital, particularly with respect to nursing staff. Writing materials were not easily accessible, making formal complaints difficult. Complaining was seen as futile and patients thought that attempting to do so was seen as their being unco-operative. Patients also needed information on non-legal matters such as finance and this was often not available.

The general opinion among users was that consultant psychiatrists know very little of what is happening on a ward and may visit a patient perhaps once weekly. Patients are reliant on nursing staff for their assessment, support and care. In some instances the normal everyday tasks of writing letters or receiving messages became entangled in nurse/patient power relationships where writing materials were not made available or messages not passed on. One user stated that submissiveness was the best means of achieving discharge from a locked ward.

In the light of these comments it is not surprising that so few patients attend court, give evidence or contest section 18 applications. What is more interesting is why so many patients are represented and do attend court, as the impression given by interviewees is that this would be a very difficult experience for them to contemplate.

Treatment

Experiences of medication were often unpleasant and destabilising. Finding the appropriate regime could involve 'trial and error', which could cause distress and discomfort as different drugs were used and assessed. Diagnoses of conditions could change after admission and this led some to feel that they had lost trust in the medical profession and could lead to refusal of treatment. Compulsory use of depot injections and ECT were particularly objected to and for these and other treatments patients reported distress over side-effects. Some patients and MHOs felt that nursing staff and consultants were not very aware of patients' legal position and were often unhappy with patients' rights to refuse or withdraw consent for medical treatment.

Interviewees stated that when they first presented for treatment diagnoses might change and a variety of different drug treatments could be tried. With some treatments there are quite rapid changes from one drug to another. In addition, the full effect of a particular drug might not be felt for 2-3 weeks. Furthermore, when the treatment is changed the patient would be required to stop treatment for a period of weeks before starting with a new drug treatment. All of these factors can destabilise a patient considerably and lead to reluctance to comply with medication. Respondents expressed concern about the lack of appreciation of these various aspects of drug treatment and described the side effects that were distressing for family

members and for work associates to see. Respondents felt that such behaviour confirmed the already negative images the public had of those who experience mental illness.

The medical perspective

Medical staff have to balance the needs of the patient with the needs of the community, many patients will be judged as being a danger to themselves and/or others without treatment. As outlined above, many patients have long-standing problems and are admitted to hospital at crisis point. By their own account, patients entering hospital are often confused and disorientated and very much in need of help. Effective treatment has to be identified within the legal framework and time-scale of the MHA.

Doctors described the orders available under the Act in terms of ascending control – section 24 (72 hours) is at the least interventionist end and section 18 (6 months) at the most interventionist end of the scale. However, the time-scales of the orders do not always fit those of treatment regimes and medics said that they use the orders to work with treatment regimes and their impact. In interview, psychiatrists reported that they used different types of court order to support treatment regimes. Orders were used in order of increasing control and compulsion - beginning with a section 24 order and with section 18 orders as the most interventionist orders.

Treatment plans can be very complex and may need to be changed during the course of an order. Psychiatrists felt that it was unnecessary to obtain a second opinion where minor changes were required.

Interviews with patients and carers show that hospital admissions occur after long-standing problems reach crisis points. Several commented that they had sought medical and hospital assistance earlier but with no success. Diagnosis and identifying an effective and viable treatment regime can take time, drugs take time to take effect and the impact of regimes on clients has to be assessed. Several treatment regimes may be attempted until a solution is found. This must all occur within the time-span of the section 26 order - 28 days - and it is clear that the processes of hospitalisation and treatment are difficult and stressful for clients and carers.

APPENDIX 2

RESEARCH METHODS

MENTAL HEALTH OFFICER SURVEY

Introduction

MHOs are social workers who have expertise in mental health matters. It was known from the outset that the majority of section 18 applications are made by MHOs, rather than by nearest relatives. Before making the application, the MHO must interview the patient and be satisfied that detention in hospital is appropriate. They must also tell the nearest relative that the application is being made. The researchers assumed (rightly as it turned out) that as MHOs make the application to the court, it is quite likely that they would also attend the court hearing. It was therefore possible that in many cases, the MHO would have information about the patient's capacity to understand the court process, the involvement of the nearest relative, legal representation, whether the application was contested and who was called to give evidence.

Method

The researchers devised the questionnaire after identifying what information was required by the research and which pieces of this information could be provided by MHOs. As far as possible, closed questions were used to speed up the analysis at the end.

Samples

A total of 1055 new section 18 detention orders were granted in the 1998-1999 financial year. The figure of 1055 includes 8 cases where the local authority was not identified and these were not included in the MHO survey. Of the remaining 1047, 8 of these were clients who had been subject to 2 orders in the course of the financial year. To avoid any confusion, these 8 were also discounted so that when the cases were sampled it would be possible to send only one questionnaire relating to any client. The local authorities to which this applied were:

Aberdeenshire (1 case)
Dumfries & Galloway (1 case)
Dundee (2 cases)
Edinburgh (2 cases)
East Renfrewshire (2 cases)

There was therefore a total sample of 1039 clients.

1055	=	Total number of section 18 orders granted in 1998-1999 (fiscal year)
1047	=	1055 minus 8 clients whose local authority could not be identified
1039	=	1047 minus 8 orders (second orders granted on 8 clients in the year)

The number of detentions granted in each local authority varied from 5 in Clackmannanshire to 154 in Glasgow. As we were relying on the goodwill of MHOs across the country it was decided that a stratified sample would be used to reduce the burden on MHOs in those authorities that had a large number of orders.

A cut-off point of 31 cases was chosen. 31 was chosen after speaking to representatives in each local authority. It was agreed that this would not impose too great a burden on the local authorities but would still allow the project to have a significantly large enough sample. As Perth & Kinross had 31 cases this was chosen (rather than 30) as it allowed another 100 per cent sample. Those local authorities having 31 or fewer cases received questionnaires for all their cases. A 60 per cent random sample was taken for all those authorities with more than 31 cases, with the exception of Glasgow and Edinburgh. Because these local authorities had substantially more cases than the other local authorities, a 50 per cent sample was taken instead.

A random sample was generated by SPSS from the data collected from the MWC. This resulted in a questionnaire sample of 739. Table 1.1 shows the number of orders granted to each Local Authority (from MWC records) and the number of questionnaires sent to each authority. The fourth column shows what percentage of the total number of orders was sent in each sample.

Table 1.1 Detention questionnaires

Local authority	Number of orders	Number of questionnaires sent out	Sample - % of all orders
Aberdeen	61	35	60
Aberdeenshire	11	10	100
Angus	16	16	100
Argyll and Bute	29	29	100
Clackmannanshire	5	5	100
Dumfries and Galloway	42	27	60
Dundee	55	32	60
East Ayrshire	14	14	100
East Dunbartonshire	9	9	100
East Lothian	13	13	100
East Renfrewshire	16	14	100
Edinburgh	128	66	50
Falkirk	23	23	100
Fife	88	57	60
Glasgow	154	77	50
Highland	44	29	60
Inverclyde	30	30	100
Midlothian	20	20	100
Moray	14	14	100
North Ayrshire	24	24	100
North Lanarkshire	37	24	60
Perth and Kinross	31	31	100
Renfrewshire	36	20	60
Scottish Borders	25	25	100
South Ayrshire	23	23	100
South Lanarkshire	37	24	60
Stirling	8	8	100
West Dunbartonshire	19	19	100
West Lothian	35	21	60
Missing data	8		

TOTAL	1047	739	N/A
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How questionnaires were sent out

- **Pilot**

A pilot involving 10 questionnaires was carried out with the help of the Association of Directors of Social Work who sent a questionnaire out to 10 different local authorities - 7 were returned. The questionnaires were revised following the pilot and after consultation with parties with key policy interests.

To assist with the distribution of the questionnaires to MHOs, the MWC provided us with a list of contacts within local authorities and a co-ordinator was appointed from each authority who agreed to distribute the questionnaires to the MHOs.

In the first stage of the research clients were only identified by their 5-digit MWC numbers. Local authorities, however, do not identify clients by these numbers but by their names. The questionnaires had to be case-specific and therefore a method for identifying each client was required so that MHOs would be able to provide information about their cases. Permission was sought from and granted by the MWC for research access to clients' names.¹⁷ These were sent to local authorities with their respective MWC numbers and the client's MWC number was written on the questionnaire. MHOs were asked not to write the clients' names on the questionnaire so that the data extracted from the questionnaire were, like the data in Stage 1 of the research, identifiable only by the MWC number.

These methods were used in all local authorities except Glasgow, Edinburgh, Fife and Dumfries & Galloway. To assist the 3 biggest authorities with the largest number of cases, the MHO who dealt with each client's case was identified from MWC files and the list sent to the co-ordinators showed the clients' names, MWC numbers and MHOs' numbers. This was also undertaken for Dumfries & Galloway due to problems they had with identifying MHOs.

Once the lists had been drawn up, the questionnaires were sent with self-addressed and pre-paid envelopes to each co-ordinator. A deadline of 2.5 weeks was set but this was extended by 2 weeks. This was a very short time-scale for responses to a postal questionnaire, but the overall time for the study was somewhat restricted. In the circumstances, the response rate and speed of response from MHOs was, for the most part, exceptionally good. Questionnaires continued to be returned up until the first week of January 2000.

- **Problems**

The questionnaires related to cases that, in some instances, had taken place over 18 months beforehand. So in several local authorities, MHOs had either left the authority or were on leave or sick leave. In most cases, this meant the loss of only one or two questionnaires. In some cases, however, these absences meant that a substantial number of questionnaires could not be filled in. Where possible other cases were substituted from those clients whose MHOs were available.

¹⁷ Scottish Executive researchers and those contracted by the CRU are bound contractually and professionally by a strict code of confidentiality and ethical requirements.

Administrative problems in some local authorities meant that the list of client names was not used and in one case, questionnaires were sent to the wrong MHOs by the local authority concerned. Where possible, these problems were dealt with.

- **Response**

By 5 January 2000 522 questionnaires had been returned - a 71 per cent response rate. Five local authorities (Clackmannanshire, East Renfrewshire, Falkirk, Midlothian and Scottish Borders) had a 100 per cent response rate. 17 local authorities had a response rate of over 70 per cent.

Table 1.2 Samples and response rates

Local authority	Sample %	Number of questionnaires sent out	Numbers returned	Response Rate (%)	Number of orders	Response rate as % of total
Aberdeen	60	35	27	77	61	44
Aberdeenshire	100	10	9	90	11	82
Angus	100	16	15	94	16	94
Argyll & Bute	100	29	19	61	29	66
Clackmannanshire	100	5	5	100	5	100
Dumfries & Galloway	60	27	5	19	42	12
Dundee	60	32	31	97	55	56
East Ayrshire	100	14	13	93	14	93
East Dunbartonshire	100	9	7	78	9	78
East Lothian	100	13	10	77	13	77
East Renfrewshire	100	14	14	100	16	88
Edinburgh	50	66	47	71	128	37
Falkirk	100	23	23	100	23	100
Fife	60	57	25	44	88	28
Glasgow	50	77	50	65	154	32
Highland	60	29	19	66	44	43
Inverclyde	100	30	13	43	30	43
Midlothian	100	20	20	100	20	100
Moray	100	14	12	86	14	86
North Ayrshire	100	24	20	83	24	83
North Lanarkshire	60	24	15	63	37	41
Perth and Kinross	100	31	17	55	31	55
Renfrewshire	60	20	11	55	36	31
Scottish Borders	100	25	25	100	25	100
South Ayrshire	100	25	15	60	23	65
South Lanarkshire	60	24	16	67	37	43
Stirling	100	8	2	25	8	25
West Dunbartonshire	100	19	18	90	19	90
West Lothian	60	21	19	90	35	54
Missing Data					8	
TOTAL*		739	522	71%	1055	49%

*Total = 1055, made up of 8 cases where the local authority was unknown and 1047 cases, including 8 where the client was made subject to 2 orders during the financial year 1998-1999

CASE STUDIES

Sampling

The aim of these case studies was to capture the way in which the Act was applied in different parts of the country. Scotland has distinct geo-physical characteristics - urban, rural and island communities and incorporates differing social traditions within its boundaries. With this in mind, three courts in very different areas were selected for in-depth study.

From information provided by the Scottish Court Service it was possible to choose three courts that had dealt with around 50 applications or more. This allowed statistical analysis to be carried out without cell sizes becoming too small.

The courts chosen for the study are neither statistically representative nor comparable but offered a snapshot of how things are done in a particular area at a particular point in time. Whilst this study cannot fully capture the wide range of influences there may be in other areas of the country, it is hoped that this approach will allow a deeper understanding of the administration of the Act and the roles of those involved.

Access to the three courts was arranged through formal access agreements between the Central Research Unit and the Sheriffs Principals.

Mental Health Act court forms and procedures

Form 2

An application for a detention order is made on Prescribed Form 2 by a MHO to the court. On the form the MHO must set out the reasons for the application and state whether they agree with the patient's doctors that the order should be made and why. Form 2 also records the decision of the court.

Form 3

Two Prescribed 'Forms 3s', that contain medical recommendations, accompany each application. Under section 20 of the Act, one of the medical recommendations must be given by a doctor who has been approved by a Health Board as having special experience in the diagnosis or treatment of mental disorder. The other medical recommendation should be (and usually is) given by the patient's GP or another doctor who knows the patient. In addition to the prescribed forms, a supplementary report from a GP or psychiatrist explaining why an application had been withdrawn, or to clarify a particular aspect of the application, is sometimes included.

Sheriff Court Rules

The Sheriff Court Rules prescribe the other documentation to be found on court records. Such documentation takes the form of standard letters. A prescribed letter (also known as Form 3) is sent to the doctor responsible for informing the patient of the application (the

RMO). This gives the date, time and place of the hearing and is accompanied by a form to be returned to the court by the RMO. This states that the patient has been informed of the hearing and records whether the patient plans to attend the hearing and whether the patient wishes to be legally represented.

A section 18 application must be heard within five days of the application form being lodged with the court. These five days do not include weekends or court holiday. (s2(3B) of the Mental Health (Detention) (Scotland) Act 1991). Once the section 18 application is lodged the patient can continue to be detained until the order has been made or the case dismissed by the court.

Analysis of Court court records

Court records – contents

Court records associated with a detention order are fairly slim. They are predominantly made up of prescribed forms and lack the broad range of correspondence often associated with a court action.

Court records usually contain the following:

1. Prescribed Forms
2. Standard Letters and Forms relating to Sheriff Court Rules (see above)
3. Notes on Continuations
4. Separate MHO Reports (although such a report was filed in only one case in Court A)

Continuations

Hand-written notes by Sheriff Clerks indicating continuations and new hearing dates are also included in case notes.

Variations in Record record Keeping keeping between courts

All Sheriff Clerks had taken time to separate out records by decision and made them available to the research team. Courts B and C photocopy all mental health applications but Court A retains only those applications which have not been granted or have been withdrawn. The papers for those applications that have been granted are returned to individual hospitals. Basic information about successful cases (such as patients' names, dates and decision) is recorded in a ledger.

Court A - accessing court papers

This was an unexpected hurdle that was only discovered after access to the court had been agreed. However, copies of court papers are sent to the MWC. The information recorded in the ledger was sufficient for the research team to identify relevant cases within MWC records and to obtain information about the cases from the court papers held by the Commission.

To identify the relevant cases at the MWC, information was selected from the MWC database on applications from hospitals in the Court A area, within the time period. Cross-referencing

was done using names and dates of birth of individual patients. Individual records were taken from the MWC stacks and information recorded from them.

All of the above made cross-referencing time-consuming. To complete the case studies in time therefore, every second successful application to the court was scrutinised.

Sampling

All section 18 applications and section 26 and section 30 appeals for this year were selected in each court. Records pertaining to all applications over this period were available in Courts B and C.

All unsuccessful applications and about one third of successful applications in Court A were analysed. A sample of successful applications was used because of time restraints.

Identifying relevant records

Although all records were organised in date order, there was no common numeric identifier among records. The year in individual court records was prefixed by a reference particular to that court. This often incorporated letters and numbers.

Records held in each of the courts were extracted and re-filed by sheriff deputies and were readily accessible to the researchers. MWC records were held in eight foot high stacks and were selected by the researcher but re-filed by records staff.

MWC records were filed in numeric order. Each record has been given a unique 5-digit reference number. These were re-arranged in numeric order to allow selection of individual records. Problems were encountered, however, in relation to relevant dates. The MWC record the date when an order becomes effective rather than the date of application. This became evident early on in the selection process and was readily modified.

Identifying appeals

Very few orders are appealed. An appeal takes the form of a writ and this enabled appeals to be identified from amongst the court records in Court C. In Court A, a full hearing accompanied by the usual forms and several reports would identify an appeal. In Court B, the papers on the one appeal heard in that court were filed separately and extracted by the court clerk.

Identifying court records in MWC files

MWC records are bulky and detailed and do not lend themselves easily to this form of research. Not all court papers were in MWC files since there is no legal requirement for these to be held by the MWC. This led to gaps in information. However, in general, information was adequate to allow comparison between courts.

How Information was recorded

Data from court records were analysed using Access 2000 and Excel. To speed up the process, data were collected in 2 stages: take-off sheets were prepared to log data directly from court files. These data were keyed in during a separate exercise. Preliminary take-off sheets were prepared beforehand and finalised during an initial visit to a court.

This two-stage process was valuable since it allowed take-off sheets to be amended to take account of the variations in record keeping within different courts.

GAPS IN INFORMATION

Evidence

Form 2 allows space on which to record whether evidence was heard and from whom. However, information from interviews suggests that discussions among sheriffs, solicitors and MHOs often take place within the hearing but are not recorded as formal evidence. These discussions may include appointment of a curator ad litem, the need for an adjournment or arranging legal representation. Patients may also address the court without being formally sworn in. None of these informal discussions is recorded in the court records.

Legal Representation

In some cases it was not clear whether a client was represented in court since this information was missing from the court records. However, this information could often be gathered from elsewhere in case notes. For example, records might record telephone calls to the court from the solicitor representing a patient.

Number of Appeals

These are recorded centrally by the Central Legal Office, which acts for Trusts in Appeal cases. Some difficulty was encountered in cross-referencing CLO information with court records. There may well be some discrepancy in figures of Appeals.

Ethnic Minorities

Very few applications were identified from ethnic minorities. This may be due to the fact that patient's ethnic origins are not routinely recorded in the court papers. Patients' ethnic group or first language was occasionally mentioned in reports or on the papers where it appeared to be relevant (for example, because an interpreter was required).