While the removal of the legal proceedings of the Mental Health Act from a Courtroom setting purported to be in the patient's interest, it has had the opposite effect. It has given psychiatrists all the advantages.

I know of no one who believes that justice is served through the Tribunal system. The overwhelming number of people who have experienced first-hand the Tribunal service have concluded it is totally ineffective in meeting the needs of the patients and is totally designed to support all its sister public sector groups.

As Co-author of the draft response from the CPG on ASD, I welcomed the Tribunal proposal, but have found now that in the experience of all parents with ASD children that the system is drastically lacking practitioners with the knowledge to rule on these cases.

Perversion of the course of justice, defamation of character and perjury are unable to be challenged when they are removed from the judicial arena.

In a Courtroom all discussions carried out in full hearing of both sides of a dispute. The Tribunal allows the psychiatrist to have sole access to them without the patient's side knowing what is said and no chance to give their side of the story. This should never be allowed to occur.

A patient, when ill, needs all the support of the law and the legal system behind him. Removing these proceedings behind closed doors has left them open to abuse which after this period of time seems to now be standard practice.

When this subject was raised at a recent Mental Welfare Commission "Road Show" Dr Lyons said that the proceedings will not be returned to the Courtroom.
One wonders if all decisions are already made and the public consultation a public relations exercise.

Criteria for investigation by MWC
Recent request for information regarding this criteria reveals that cases that match the criteria are not being investigated. The "safeguards" within the Act are therefore ineffective.
This is abuse of Human Rights.

Patient Access to tribunal
NO PATIENT SHOULD EVER BE DENIED ACCESS TO HIS/HER OWN TRIBUNAL NO MATTER WHAT THEIR MENTAL STATE.

Composition of Tribunals

I carried out a small poll of people at several hustings prior to the last election. All of these were involving Mental Health Groups. Everyone agreed that the "lay person" on a Tribunal should be just that: a person with a neutral standpoint and not a member of the psychiatric profession. (Most certainly it should not be someone who has previously worked with the patient.) Every attempt should be made to have a psychiatrist outside the patient's health board area and with the appropriate expertise.Better background information needs to be given in advance to the patient and named person regarding those who will compose the Tribunal, so that objections can be made and no time and money wasted in delaying proceedings through last minute objections.

Consistency of Tribunal panels.

When proceedings are continued, every effort should be made to have the same Tribunal members. When a further Tribunal is requested even after several months, strong attempts should be made to have the same Tribunal members.
This will save time, public money and stress on all concerned.

Documentation.

Every effort must be made to get productions to the Tribunal in time for this to be read AND for clarification from others to be sought if needed on areas where the Tribunal has no expertise.

Expertise

Medicine has grown over the last century to be a highly specialised field with many areas of expertise . Doctors regularly have input from biochemists, toxicologists, geneticists,

pharmacists, etc. Reports from people with this expertise, particularly where their academic status exceeds the psychiatrist, should not be dismissed by the Tribunal because the authors do not have a medical qualification.

This is particularly relevant where the contention is that the patient is suffering from a treatable medical condition which the psychiatrists have failed to recognise.

Where contrary opinions to the RMO's are given by academically superior psychiatrists, this should carry more weight with the Tribunal.

Evidence

Where "evidence" such as Risk Assessments and Second opinions are made, there should be a requirement of proof for serious allegations. For example, if it is stated that someone has been "jailed," then the onus is on the author of the report to produce documentation to prove this is the case. Or, if is said that the patient injured someone to the extent that they needed hospital treatment, then a report from A&E should be produced.

It should not be up to an ill patient to have to source counter- evidence for allegations like this. In this country you are innocent until proven guilty.
According to a local advocacy service, this unsubstantiated blacking of a patient's character is commonplace in our health board area. It is totally unethical.

Where documentary evidence is given by the patient that allegations such as above are fictitious, this should not be ignored by the Tribunal panel.

Recorded matters

This, I understand, was brought in to give a patient a degree of reciprocity.
When Recorded Matters are given, the CTO is allowed, with a caveat: that these Recorded Matters should be carried out within a given time. It is a record of the concern that the Tribunal has over the care of that patient by that RMO.

The patient wins the Recorded Matters. It should be that those who win have some say in whether the Recorded Matters have in fact been completed. To allow the psychiatrist whose lack of care triggered the Recorded Matters to have the only say in whether they have been carried is a farce. This is not justice, but a demonstration of the "closed shop." that is practised within psychiatry.

I have been informed that the only way for a patient or named person to challenge whether these are carried out correctly is to have another Tribunal. This is a terrible waste of public money. The Tribunal Service needs to have some powers to enforce and the patient and named person must have a say. Surely some sort of input from the Tribunal members who gave this finding is not beyond organising on an informal basis.

Learning Disabilities and Autistic Spectrum Disorders

These disabilities have no place in the Mental Health Act. There were recommendations in the Milan and McManus reports that this should be reviewed.

In the case of ASD all the modern research points to underlying medical conditions. Clearly this is not mental illness. The current "care" is causing damage and adding further metabolic problems to those that are already there. Poor detoxification and tolerance to drugs is well researched in this group, but the lack of expertise in this field in Scotland is putting these patients at risk. Current SIGN guidelines do not recommend investigation. NICE does allow for this.
(One of the drugs recommended by SIGN, Risperidone, is clearly NOT recommended by the Cochrane Collaboration, because of the severe side effects. Why does SIGN have a different point of view?)

Mental Welfare Commission

This body is failing to investigate abuses of power, such as detention in a locked ward without Sectioning, drugs being given forcibly to patients with a proved detoxification problem and severe side effects from drugs. Some of these abuses concern Human Rights issues.
The MWC psychiatrists do not contact families who have complained of a family member's ill treatment, with the result that the true story is never told.

The MH Act

At the SAMH Edinburgh hustings ALL representatives from all the political parties, including Shona Robison, stated that the current Act was not fit for purpose.

Rather than endless amendments, it would be better to repeal this Act and start again, having learned from past mistakes.