

ARTICLE

# Mental health tribunals in England and Wales: a representative's guide

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## SUMMARY

Consultant psychiatrists are familiar with mental health tribunals, at which they appear as key witnesses giving both factual evidence and expert opinion. They also commonly act as the representative of the 'responsible authority'. The implications of this in terms of roles and responsibilities, and in terms of training and continuing professional development, have received little attention. Psychiatrists should not accept a representative role unless they are sure that they have the necessary competencies and resources – competencies that are alien to most clinicians and resources that are not available in many services. This article outlines those requirements so that psychiatrists can make better-informed decisions about whether or not to undertake the role and provides practical guidance for those who choose to do so.

## DECLARATION OF INTEREST

None.

Despite their relative informality, mental health tribunals (MHTs) are legal proceedings that address one of the fundamental human rights: the liberty of the individual. The outcome of a tribunal is of great importance to the detained patient, but the interests of others are also involved. The consequences of unjustified detention or premature discharge are significant for the responsible authority (often called the RA), the individual responsible clinician (often abbreviated to RC) and the public (Prins 1997). It is, therefore, surprising that the responsible authority rarely appoints a legally qualified representative and in most cases is not represented at all.

In England and Wales, procedures are governed by the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 (the 'MHT Rules'). There are different provisions in other jurisdictions, including Scotland and Northern Ireland, and although many issues will be common to other settings, this article will deal specifically with the situation in England and Wales. The MHT Rules refer explicitly to the informality of tribunal hearings, and permit tribunal judges considerable discretion

to organise and manage proceedings as they see fit. This may lead some psychiatrists and managers to underestimate the legal status of the hearing: many seem to accept discharge by a tribunal more in the spirit of a minor disagreement of clinical opinion than an upholding of a serious legal challenge. The non-adversarial nature of MHT proceedings may also disguise the fundamental conflict between the interests of the patient and those of the hospital and psychiatrist seeking to continue detention.

Psychiatrists are familiar with giving evidence to tribunals. In legal terms, this includes evidence of fact (what the doctor *knows* about the patient's presentation and treatment) and opinion (what the doctor *believes* about issues such as diagnosis and prognosis). Although they are often invited to discuss issues beyond the immediate medical management of the patient, as witnesses psychiatrists are ultimately there to provide information that will assist the tribunal. A witness is obliged to give accurate and complete evidence ('the truth, the whole truth and nothing but the truth') whatever the consequences for the outcome of the case.

The role of a representative is fundamentally different. Although there remains a duty to assist and cooperate with the tribunal, the representative's role is to present a case as instructed by the party they represent. This will usually include making submissions on points of law and the facts of the case, questioning witnesses to bring out the points of evidence that support the case and expressing a view on issues of procedure so as to protect the party's interests. They must never mislead the tribunal, but representatives must also conduct the case in accordance with the instructions of the party that they represent.

## The roles and responsibilities of the representative

Neither the Mental Health Act 1983 nor the MHT Rules are explicit about the role of the representative at a tribunal; what guidance there is tends to be written from the perspective of patients' representatives (Gostin 1992; Eldergill 1997; Law Society 2011) and gives little instruction to those representing trusts. Representatives have a duty both to promote the case presented

by the party that they represent and to help the tribunal in reaching the correct decision. We suggest that this encompasses the roles listed in Box 1. To discharge these duties, we suggest that a representative would normally be expected to have the knowledge and skills listed in Box 2.

### Should psychiatrists represent the responsible authority?

We would urge psychiatrists to think carefully before accepting the representative role. Most psychiatrists will lack the skills and competencies required, as well as the necessary resources and support to discharge the duties adequately. The consequences of providing inadequate representation are significant. This article aims to elucidate what the representative role entails, so that psychiatrists are better placed to make an informed decision whether or not to represent. For those who do, we hope the suggestions will be useful; for those who do not, the identification of the competencies and resources required may help to explain and justify that decision.

Several factors support the practice of a responsible clinician acting as representative. It has been common practice, has given rise to little apparent concern or comment and contributes to the relative lack of formality of the proceedings. It also allows the responsible clinician, who should be the person most familiar with the case, to take an active part in the hearing, for example offering an opportunity to correct misunderstandings or misleading information given by others. In a UK survey, the majority of consultant psychiatrists indicated that they would want to act as a representative (Nimmagadda 2008).

On the other hand, there are significant reasons why responsible clinicians may not be the best people to represent the responsible authority. Most importantly, they usually lack the legal knowledge and experience required. Clinicians' knowledge of the Mental Health Act has been found to be variable (Harrison 1996; Humphreys 1998; Bhatti 1999; Peay 2001), particularly on issues away from the day-to-day application of the Act. The rapid growth of MHT case law and the introduction of the Human Rights Act in 1998 (Bindman 2003) means that many of the legal concepts are considerably removed from the experience of responsible clinicians (Passmore 2003). A UK survey of consultant psychiatrists (Nimmagadda 2008) found poor levels of knowledge and understanding relating to MHT procedure, particularly in relation to the role of the representative, suggesting that many responsible clinicians will be significantly disadvantaged compared with experienced mental

#### BOX 1 Responsibilities of a representative of the responsible authority

- To articulate a case for detention that is justified by the evidence presented and by relevant legal authority
- To ensure that witnesses for the responsible authority address the relevant statutory criteria
- To ensure that witnesses for the responsible authority are enabled to express their opinions fully and clearly
- To identify and address the legal issues relevant to the case and to present and interpret the statute and case law authority on which the responsible authority's case relies
- To test the accuracy of factual evidence and the justification for opinion evidence presented on behalf of the patient, and to challenge this vigorously where appropriate
- To respond to legal issues raised by the patient's representative or the tribunal, interpreting or distinguishing authorities where appropriate
- To participate actively in all discussions relating to the management of the proceedings to ensure that the responsible authority is not disadvantaged
- To provide (directly or through the involvement of other witnesses) any information that will assist the tribunal in reaching an appropriate decision or in understanding the implications of that decision for the patient's future management
- To acknowledge any weaknesses in the responsible authority's case and to ensure that the case presented is not misleading
- Never to mislead the tribunal

health lawyers who generally represent patients. Guidance for doctors appearing before tribunals generally relates to the role as witness, rather than representative (Lodge 2005).

#### Conflicts of interest

It is generally considered important that an advocate in legal proceedings should not be personally

#### BOX 2 Skills of a representative of the responsible authority

- Have a detailed understanding of both the statutory and case law relating to detention under the Mental Health Act 1983, including the application of human rights legislation
- Understand the techniques of statutory and case law interpretation and be able to present a valid legal argument based on this
- Have advocacy skills sufficient to present and argue a legally robust case
- Be familiar with the details of the evidence to be presented on behalf of the responsible authority and understand the legal justification for continuing detention based on that evidence
- Recognise any weaknesses in the responsible authority's case and how they affect the justification for detention
- Recognise the ways in which the patient's representative is likely to challenge detention and the legal issues that this challenge will raise
- Know the scope and limits of the representative's rights during the tribunal hearing, so as to be able to intervene effectively
- Understand the functioning of the mental health tribunal (MHT) as an inquisitorial rather than an adversarial tribunal
- Understand the rules regarding admissibility of evidence before MHTs and the distinction between factual and expert evidence
- Be confident to intervene assertively but constructively during the proceedings
- Be skilled in the questioning of witnesses so as to establish the points necessary to the responsible authority's case and to test thoroughly the evidence and opinion given on behalf of the patient

interested in the outcome. In an MHT, the practice of the responsible clinician and the ongoing decision to continue detention are precisely the issues that are being challenged. Moreover, there are potential conflicts between the interests of the responsible authority, which the representative should be expected to protect, and those of the responsible clinician explaining and defending his or her own professional practice.

There are even more significant conflicts between the role of a representative and a doctor's overriding professional duties to the patient, who must always remain the doctor's first concern (Sarkar 2005). Unlike a lawyer, a psychiatrist may feel inhibited from actively challenging the evidence given by witnesses during the MHT because doctors are trained in consensual and team-based working rather than adversarial confrontation. It is also inherently difficult to challenge and undermine colleagues such as nurses (with whom the psychiatrist must continue working), other clinicians giving independent evidence on behalf of the patient (who may have continuing professional contact with the psychiatrist) and, most crucially, the patient.

A responsible clinician acting as representative may be inhibited from cross-examining thoroughly a patient with whom he or she has to maintain a positive therapeutic relationship long after the MHT. Manuals for lawyers (Du Cann 1964; Napley 1991) give considerable detail about cross-examination techniques that would sit uncomfortably in any doctor–patient relationship.

### *Alternatives to responsible clinicians representing*

If the responsible clinician is not to represent the responsible authority, what alternatives might there be (remembering that this is ultimately an issue for managers to determine)? One option is for the authority to be unrepresented – arguably this has always been the case in many tribunals where the doctor has not taken an active representative role. However, this may underestimate the legal importance of the hearing and the consequences of a wrong decision resulting from a failure of the responsible authority to present a robust case.

Another option is for the responsible authority to engage qualified legal representatives, which already happens in a small number of high-profile cases, but to do so routinely would divert substantial funds from activities more directly related to patient care. A third option would be to identify appropriate members of staff, not directly involved in a particular case, who might take on this role. Responsible clinicians with experience

of MHT procedures might be well placed to do so, perhaps with further training and supervision, but managers, approved mental health professionals (AMHPs) and others might also have the requisite skills and experience.

### **Acting as a representative**

As a consultant psychiatrist, if you are approached by the responsible authority to represent them at an MHT, you need to know what that will involve. This section will guide you through the process, and our top tips are summarised in Box 3

#### *Before the hearing*

The MHT Rules now stipulate that all representatives must be appointed in writing. Psychiatrists should consider and actively decide whether or not to take on this role and seek agreement between the responsible authority (which may choose to be represented by someone else, or not at all) and the responsible clinician (who may be reluctant to take on this role even if the responsible authority requests it).

#### **Allocating time to prepare**

Acting as representative is not something that begins at the hearing – proper preparation is essential. It is essential to allocate sufficient time and resources for preparation: solicitors representing patients typically spend several hours preparing for a hearing. As the responsible clinician you may be able to save some time, being familiar with the case, but you may need extra time to get to grips with the legal issues. The time for preparing as representative should be additional to the time that would be spent

#### **BOX 3 Top ten tips for representatives**

- 1 Do not accept the role unless you are sure you can fulfil it competently
- 2 Preparation is key
- 3 Play to your strengths – do not try to 'out-lawyer the lawyers'
- 4 Do not overcomplicate – keep it simple
- 5 Be constructive, not confrontational
- 6 The responsible clinician has credibility – use it
- 7 Consider three domains: facts, issues and legal rules
- 8 Relate your arguments to the statutory criteria considered by the tribunal
- 9 Explicitly address role conflicts
- 10 Access legal advice when necessary

preparing to give evidence (writing a report, reading notes and other reports, interviewing the patient) and should be identified within the job plan. You may need additional support by way of secretarial assistance and access to up-to-date law reports and legal texts and to qualified legal advice where appropriate.

### Being aware of your responsibilities

As soon as it is decided that the responsible clinician is to act as representative, the MHT office should be informed in writing. Once appointed as representative, you become the primary point of contact for service of documents, but you must keep the authority informed of progress. Parties have a duty to cooperate to avoid unnecessary procedural applications or delays. This may include prehearing discussions (for example, to agree on disclosure or non-disclosure of specific information to the patient) or the attendance of witnesses; the representative will need to take the initiative in arranging these. In particular, if an expert report has been commissioned on behalf of the patient, consider whether you wish the author to attend: tribunals are unlikely to agree to an adjournment for this if the issue could and should have been resolved by the representatives in advance.

### Understanding the legal issues

As the responsible clinician, you will need to spend time understanding the legal issues that arise and applying them to the clinical situation. Case law regarding MHTs has changed rapidly and has to be applied to the current case – a digest by Gledhill (2009) of ‘essential cases’ runs to 20 sections, 127 pages and 136 cases. A legal decision can be thought of as arising from the interaction of three domains: the facts of the case; the legal issues that arise from the facts; and the legal rules that apply to those issues (Holland 2003). You will need to be able to analyse these elements of decided cases to apply them to your own case or to distinguish them from it.

### Constructing your argument

Once you understand the relevant legal rules and how they support the responsible authority’s case for detention (or how they can most favourably be interpreted and presented as supporting it), you should construct the outline of the legal argument that you will present to the tribunal, applying the rules to the facts of the case. You must also consider the case from the patient’s point of view and anticipate the arguments that will be made on

the patient’s behalf and what factual evidence and legal argument you will present to the tribunal to rebut them. All of your arguments should be relevant to the statutory criteria that the tribunal will consider: much information that is important clinically may not address the relevant legal issues and the crucial legal point may rely on evidence that is of limited clinical significance.

### Familiarising yourself with the evidence

You will need to be conversant with all of the reports submitted and any other evidence that is to be presented. Having identified the key issues on which the responsible authority will seek to rely, identify the crucial pieces of evidence that establish those points, as this is what you will need to emphasise during the hearing. You may need to request additional reports or updates to ensure that the evidence is available to support your legal points.

A representative should not, of course, ‘coach’ witnesses to give particular evidence. Be aware of a possible conflict of interest here if you are seen to produce a report that is tailored too much to the representative role. As a crucial witness, the responsible clinician still has a duty to provide balanced and honest clinical evidence, even where that is unhelpful to you as representative. Conversely, as a representative you may have to select and interpret evidence, including your own, in a way that best supports your case.

Before the hearing itself, you should be clear what documents have been disclosed within the proceedings, what evidence will be presented and which witnesses are attending. Consider also whether other parties such as the Secretary of State (in restricted cases) or victims (in Mental Health Act 1983, Part III cases) will be attending or represented. Make sure that all of the witnesses you need to call are available and aware of their involvement.

### Checking your argument

Your role is to represent the responsible authority, not to present your own opinions, so confirm at this stage that the responsible authority is happy with your intended line of argument. In the rare cases in which the authority is critical of your clinical management, this is the time for you both to consider independent representation.

### Preserving the doctor–patient relationship

We strongly recommend explaining the situation to the patient, particularly why you will be questioning and criticising the evidence they give

to the tribunal and that is given on their behalf. Done well, this may minimise any damage to the ongoing therapeutic relationship. Purely as a representative, it would be quite improper for you to speak to another party in this way, so make sure that everything you say is defensible as part of your doctor–patient relationship and cannot be seen as exerting unfair influence on the patient. This applies to all clinical contact with the patient and indeed with potential witnesses from the time you are appointed as a representative.

### **Presenting the responsible authority's case**

There are few hard-and-fast rules about hearing management and tribunals have wide discretion to set their own procedures, subject to an overriding requirement to deal with cases fairly and justly (rule 2 of the MHT Rules). The relative informality of the hearing means that you can ask for issues to be raised or to be permitted to make comments at various points. Tribunal judges want to be seen to be fair and open in the way they conduct hearings, rather than enforcing strict procedural rules and they are likely to respond better to a constructive, helpful intervention than to pedantic appeals to procedure. You should remember that all parties have a right to be consulted about procedures, so if issues do come up, request an opportunity to address them.

### **Playing an active role**

If your preparation has been thorough, the hearing itself should not be too daunting. At the outset you should clarify that you will be representing the responsible authority – under the new MHT Rules written notification of your appointment will already have been given, but it does no harm to remind the tribunal and to establish yourself as an active participant in the hearing from the start. Tribunals may not be accustomed to responsible clinicians playing an active representative role in the hearing, so at times you may need to be active in asserting your rights to be heard. There may be preliminary issues to address regarding disclosure or non-disclosure of documents, the attendance of observers or others not directly involved as witnesses and the order in which evidence will be taken. In addition, a patient may request a public hearing, although this is rare. The responsible authority should have a view on all of these issues and you are entitled to express that view, with equal status to the patient's representative.

### **Deciding the structure of the tribunal**

Tribunals often offer the patient's representative a choice of the order in which evidence is heard;

you have the right to be consulted on an equal basis. The usual procedure is for the responsible clinician's evidence to be taken first; this may be helpful in separating your role as responsible clinician from your role as representative during the rest of the hearing. It could be confusing for all concerned if you are alternating between the two roles as the tribunal progresses.

### **Making an opening or closing statement**

You should clarify at the outset whether or not you wish to make an opening or closing submission on behalf of the responsible authority. Again, you have a right to equal treatment with the patient's representative, but some tribunals may need to be reminded of this. Think carefully before deciding not to make a statement. If you do not wish to make formal submissions, you should consider making it clear that you are actively deciding this, rather than being overlooked. An opening submission is an opportunity briefly to identify the issues on which you wish the MHT to focus and perhaps to consider conceding points that will not form part of your argument.

### **Giving and hearing evidence**

The responsible clinician is likely to have a considerable amount of credibility with the tribunal and should be the most familiar with the details of the case. Try to build on these strengths, rather than getting involved in a complicated legal argument that you are unlikely to win; do not try to 'out-lawyer the lawyers'. If you feel that you are getting out of your depth, it is nearly always better to admit this and most tribunal judges will be only too happy to give some guidance.

Giving your own evidence will probably come as a relief – the part of the proceedings with which you feel most comfortable and in control. With other professional witnesses, it is usual to allow them to answer questions from the tribunal, but you should also request an opportunity to ask questions yourself (usually this would be done before the tribunal's questions) to bring out the key points of their evidence.

If the patient has called independent professional witnesses then the patient's representative will usually go through their reports with them and the tribunal will question them, after which you should expect to do the same. If the tribunal members have raised the issues you wanted, it may be best to leave things at that. Where the witnesses' evidence supports your case, or can be interpreted in different ways, you should ask questions that bring this out. If the opinion is flawed or one-sided, you should aim to demonstrate this, clarifying the

basis of the opinion and any limitations. You may want to emphasise the limited contact that the witnesses have had with the patient or their lack of ongoing clinical responsibility, but most tribunals will already appreciate this and labouring the point may be counterproductive.

### Questioning witnesses

Cross-examination is a complex skill and its discussion is beyond the scope of this article. However, one thing to bear in mind is that a lawyer rarely asks a question without knowing the answer. In clinical practice, questions are asked in a genuine attempt to learn new information; in legal practice, questions are asked to lead the witness into making certain statements or admissions. The questioner generally knows what answer they expect to hear and how that fits into the case that they are trying to establish. Keeping control of the information presented is key.

### Questioning the patient

The patient will have a chance to give evidence, either by addressing the tribunal or, more likely, by responding to questions from their representative. Tribunals are usually fairly indulgent towards the patient, tolerating interruptions, irrelevant issues and disorganised evidence. This is generally a good thing, although you may want to object if this is taken too far. You should expect to question the patient and use the opportunity to clarify/correct any factual inaccuracies and to challenge any unrealistic commitments, for example about future adherence to treatment. It is acceptable, and often essential, to ask about parts of the history that the patient has left out of their account and to ask questions that put that account into context.

### Making a final submission

Finally, decide whether or not you will make a final submission. This has not been common practice and some tribunals may query this, but there does not seem to be any reason why the responsible authority and the patient should be treated differently. If you do make a submission, focus on the specific legal issues that support continuing detention and keep it as concise as possible. Do not repeat all of the evidence that has been given (although you may emphasise one or two key points) and do not use this as an opportunity to indulge your Perry Mason fantasies.

The representative must never leave the hearing before the end. You have serious responsibilities to discharge all the way through the hearing and if you are not able and willing to do so, you should not act as the representative in the first place.

## After the hearing

### Documenting the tribunal

The responsibilities of the representative do not finish at the end of the hearing. As well as letting the responsible authority know the outcome, you should ensure that you have kept adequate records of the hearing and of your input. If the decision is later challenged or questioned, you will need detailed contemporary records of what submissions you made, how the tribunal responded, what evidence was given, what points you made and so on. As with medical negligence cases, if there is no record of what was (or was not) done, you will have great difficulty in persuading anyone that you acted properly. The records should be separate from the clinical records but the responsible authority will need to decide whether they are held as part of the overall health records or in some separate format, as they would be if the responsible authority were to engage a legally qualified representative. The records relate to your duties as the responsible authority's representative, rather than as the patient's doctor, so it may be inappropriate for the patient to have access to them – after all, the clinical team would not expect access to the records of the patient's solicitor.

### Considering an appeal

Increasingly, tribunal decisions have been subject to judicial review and the new MHT Rules have made appeals more common. If the decision has gone against you, consider whether or not you will advise the responsible authority to appeal against the decision to the Upper-tier Tribunal and on what grounds: detailed records of the proceedings and any aspects that you objected to at the time will be crucial. You may also want to consider whether an application should be made to prevent the patient being discharged in the interim. If the detention has been upheld, you should consider whether or not the patient might have grounds for appeal – the responsible authority will be grateful for any advance warning. In either case, qualified legal advice is essential.

### Negotiating conflicts of interest

Before agreeing to act as representative, consider seriously whether you have the required time, resources and training. During the hearing and in the days and weeks leading up to it, you must also continue to function as the patient's responsible clinician and do both of these very different tasks adequately. Can you do this without compromising your ability to fulfil either role?

Consider your potential liabilities and indemnity for any failings. If it is seen as part of your employment, then your employer should provide indemnity. But how will this work if your employer claims that you have represented them negligently? At the very least, you should discuss this matter in advance with your medical defence organisation, since it is unlikely to have the expertise to advise on such an unusual area of practice without notice.

Throughout the process, you should be as clear as possible whether you are acting as the clinician or the representative at any particular time and make sure that your actions are appropriate to your current role. As the responsible authority's representative, it is not appropriate for you to meet with patients and discuss their detention with them, but as the responsible clinician you must do so regularly. Clear and explicit note-keeping and discussing these issues with your patient may help; other members of the clinical team may also need to be informed of the difference between the roles, so that you are not seen as unhelpful or obstructive when acting in one capacity or the other. Be as clear as possible that as a clinician you have a primary duty to the patient but that as a representative you have a duty to present the responsible authority's case and to challenge that of the patient.

When preparing a report and when giving evidence, be explicit about the difference between your own clinical opinion/evidence and the responsible authority's legal case for detention, as presented by you as their representative.

Being open and explicit about potential conflicts of interest is likely to defuse many potential problems. If you find yourself in difficulty, for example in not being able to cross-examine vigorously a vulnerable patient because of your clinical responsibilities, alert the tribunal as soon as possible. In an extreme case, you might want to request an adjournment so that an alternative representative could be appointed, although the tribunal is likely to be reluctant to do this. It would be better to anticipate such a difficulty before agreeing to act as representative.

### Training

All doctors have a duty to practise to a reasonable level of skill and competence. By taking on the role of a representative, you are putting yourself forward as someone able to fulfil that role adequately. This includes satisfying yourself that you have sufficient initial training and appropriate ongoing development and supervision. Responsible authorities also need to be assured that consultants

### BOX 4 Competencies of a representative

- Knowledge of relevant mental health legislation
- Knowledge of relevant human rights legislation
- Knowledge of relevant case law
- Ability to analyse and apply legal rules
- Ability to present legal arguments
- Understanding of tribunal procedures, the MHT Rules and relevant practice directions
- Ability to negotiate conflicts of interest

appointed as representatives are competent to discharge the responsibilities and have mechanisms in place to audit their performance. Some competencies for acting as a representative are listed in Box 4.

It is unlikely that all of these competencies will have been acquired, even by experienced consultant psychiatrists, without some additional training. There is also a need for ongoing training, particularly in relation to developing case law and evolving tribunal procedures. We are not aware of any formal training specifically aimed at the competencies needed by a representative, but there are various training opportunities in different aspects of mental health law that might meet some or all of these requirements.

It is not uncommon for mental health lawyers to practise part-time as patient representatives and part-time as legal members of MHTs. In an analogous way, it may be appropriate for consultant psychiatrists who are medical members of the tribunal to take the lead in providing representation for responsible authorities. However, although training provided for tribunal members addresses some of the suggested competencies, it would fall short in relation to others.

Given the potentially isolated role of the representative, we would suggest that consultants taking on these responsibilities should arrange some form of peer group support or supervision that would enable difficulties to be discussed, good practice to be disseminated and standards of practice to be monitored.

### Conclusions

Representing the responsible authority at a tribunal is not simply an extension of the responsible clinician's role: it is a specialised and complex task with its own skills and competencies. Before taking on such a role, responsible clinicians need to be confident that they have the competencies and resources to do so, have access to adequate

#### MCQ answers

1 b 2 c 3 d 4 a 5 d

training and supervision and can negotiate the various conflicts of interest without detriment to any of their responsibilities.

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### MCQs

Select the single best option for each question stem

#### 1 When attending a mental health tribunal (MHT), the responsible clinician:

- a invariably represents the responsible authority
- b can only represent the responsible authority if appointed in writing
- c should decide at the hearing whether or not to represent the responsible authority
- d appears only as a witness and not as a representative
- e can act as a representative only with the permission of the tribunal.

#### 2 People representing the responsible authority at MHTs:

- a must be legally qualified
- b receive training from the tribunals service
- c need a detailed knowledge of recently decided cases
- d must be an employee of the authority
- e must not be an employee of the authority.

#### 3 The conduct of MHT hearings is not influenced by:

- a the Mental Health Act 1983
- b the Mental Health Act 1983 *Code of Practice*
- c the 2008 MHT Rules
- d the Civil Procedure Rules 1998
- e the Human Rights Act 1998.

#### 4 The overriding objective of an MHT hearing is:

- a to deal with cases fairly and justly
- b to promote the best interests of the patient
- c to facilitate appropriate treatment
- d to authorise the lawful detention of persons of unsound mind
- e to enforce an individual's human rights.

#### 5 The inquisitorial nature of tribunal hearings means that:

- a representatives cannot cross-examine witnesses
- b neither party has to discharge a burden of proof
- c they are not considered to be court proceedings
- d the tribunal can consider issues not raised by the representatives
- e tribunal hearings always take place in private.