

# Balancing autonomy and risk: the Scottish approach

Jacqueline M Atkinson<sup>1</sup> Hilary J Patrick<sup>2</sup>

The impact of compulsory measures of medical treatment for mental disorders have for some time interested medical and legal commentators, possibly because of the complex ethical issues these raise. In a context where stigma and discrimination are realities for many of those who use mental health services<sup>3</sup> some people argue that holistic legislation, which places treatment for mental disorder within a more general framework of incapacity law, could reduce the stigma of mental ill health<sup>4</sup>.

Szmukler, Daw and Dawson have made an interesting attempt to show how such a law might look in practice. They have built on and reflected the work of the Bamford Committee in Northern Ireland, which, while recommending a single legislative basis for mental health and incapacity law, fell short of producing a draft bill<sup>5</sup>.

In looking at these proposals from a Scottish perspective, we have resisted the temptation to focus on points of detail and have attempted to discuss certain themes. In particular, we have looked at how Scotland has introduced a capacity-based threshold for mental health law and how this compares with Szmukler *et al*'s proposed approach.

Certain (probably non-controversial) principles underline our approach:

- Legislation should have a solid ethical foundation.
- Any law should attempt to reduce stigma and discrimination, if possible.
- Legislation imposing duties or restrictions on people with mental disorders should also grant them real reciprocal rights.
- The law should be workable for service users and for health and social care professionals.
- Legislation needs to balance respect for autonomy with the right to protection.
- The criminal justice system should also be non-discriminatory in the way it assesses risk and disposes of cases.

We have assessed the Szmukler *et al* proposals (and the Scottish legislation) against these principles.

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1 Professor of Mental Health Policy, University of Glasgow

2 Honorary Fellow, School of Law, University of Edinburgh

3 Social Exclusion Unit *Mental health and social exclusion: Office of the Deputy Prime Minister* (2004).

4 M Gunn 'Reforms of the Mental Health Act 1983: The relevance of capacity to make decisions' *Journal of Mental*

*Health Law* (2000) 39; Dawson, J, Szmukler G (2006) 'Fusion of mental health and incapacity legislation' *Br J Psychiatry*, 188:504–509.

5 Bamford Review of Mental Health and Learning Disability (Northern Ireland) (2007) *A comprehensive legislative framework*.

## Reducing stigma and discrimination

While clearly the use of compulsory measures can be both stigmatising and distressing, Szmukler *et al*'s proposed new model does not suggest that their use will cease, only that other people (those with physical illnesses) may now become subject to such measures.

We know that a diagnosis of mental illness, learning disability or personality disorder is linked to poverty, unemployment and discrimination<sup>6</sup>. It could be argued that a dedicated mental health act should properly target discrimination, by including positive measures to reduce inequalities.

The *Mental Health (Care and Treatment) (Scotland) Act 2003* makes some, albeit modest, moves in this direction, reflecting its principles of respect for diversity and reciprocity. It gives everyone with a mental disorder a legal right to advocacy<sup>7</sup> and imposes important duties on local authorities to provide not just support services, but help with accessing employment, recreation and supporting positive mental health<sup>8</sup>.

While, clearly, much more could be done, there is a danger that a generic incapacity law would not tackle the wider needs of this group. A mental health act does not need to be just about detention, it could also, as a measure of reciprocity, confer real rights and benefits.

## A single Act

Scotland now has capacity based mental health legislation (although the test is significantly impaired decision-making rather than incapacity)<sup>9</sup>. It also has separate capacity legislation, (the *Adults with Incapacity (Scotland) Act 2000*) providing a framework for decision making in the welfare, financial and medical fields, much wider than the scope of the draft bill suggested by Szmukler *et al*.

There is no doubt that, in practice, overlaps between the two are difficult. If a person needing care and treatment in a community setting resists this, is guardianship appropriate, or would a community based compulsory treatment order be preferable? Which forms of medical treatment require authorisation under incapacity legislation and which under the mental health act? In addition, of course, there are deprivation of liberty concerns.

The accepted wisdom in Scotland is that the only circumstances where an adult can be lawfully deprived of her liberty on grounds of mental disorder are under a mental health act order or with the use of guardianship under incapacity legislation. However guardianship was not designed with deprivation of liberty issues in mind and there are problems with its use in this way<sup>10</sup>.

The Millan Committee in Scotland recommended that consideration be given to fusing mental health and incapacity law into one piece of legislation<sup>11</sup>. It would be true to say, however, that this has not been a priority for government, service users or academics. Of more interest has been the recommendation for a review of the place of learning disability within mental health law<sup>12</sup>.

Such a review would look more generally at the use of compulsion in people with learning disabilities, the

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6 G Thomicroft 'Shunned: discrimination against people with mental illness' OUP (2007).

7 *Mental Health (Care and Treatment) (Scotland) Act 2003*, s259.

8 MH(CT)(S)A 2003, ss25–8.

9 See, for example, MH(CT)(S)A 2003, ss44(4), 63(5).

10 H Patrick 'Autonomy, benefit and protection: How human rights law can protect people with mental health conditions or learning disabilities from unlawful deprivation of liberty' *Mental Welfare Commission* (2008).

11 *New directions Report on the review of the Mental Health (Scotland) Act 1984* Scottish Executive (2001), recommendation 2.1.

12 *New directions* (above) recommendation 4.6.

use of guardianship to control risk and, in particular, the use of hospitalisation as a preventative measure for people who engage in inappropriate or criminal behaviour. It may be that dedicated legislation for people with learning disabilities, including those with mental illness as well as learning disability, could more appropriately meet their needs than the current legislation in Scotland (or England and Wales) or the wider incapacity law proposed by Szmukler *et al.*

## Assessing capacity

Despite calls for a capacity test in the Scottish mental health act, the Millan Committee was unwilling to recommend a purely incapacity based test. It was concerned that there might be people on the borders of the definition who would 'pass' the incapacity test but who would be thus failed by services and would not receive they help they might need.

The Richardson committee recognised this dilemma. It left it to politicians to decide whether legislation should allow a competent patient's refusal to be overturned where there would be a substantial risk of serious harm to the patient if she remained untreated<sup>13</sup>.

Millan was concerned that a purely cognitive test of capacity might not adequately reflect the role of emotion in decision-making, nor how capacity might be affected by an illness such as depression.

It might be that some of these concerns would be addressed by what appear to be changing definitions of incapacity (not generally accepted in 2001). In particular, it might be possible to argue that a person with depression is unable to 'appreciate' the true situation in which she finds herself, or properly to weigh up the options in her case. We are pleased that Szmukler *et al* include this new aspect of the definition.

However we remain concerned that any capacity test should consider the impact a mental disorder may have on a person's emotions as well as her cognitive functions. Richardson suggested one element of the test should be how far the decision is the 'product' of the disorder<sup>14</sup> and this is a concept the Scottish test attempts to capture.

We are currently carrying out research<sup>15</sup> into the way the significantly impaired decision-making test is operating in practice in Scotland, and whether it does, in fact, differ from a capacity test.

## Patient safeguards

Respect for the wishes of the service user is a crucial principle of the Scottish legislation and rightly stressed by Szmukler *et al.* The Scottish Act attempts to implement this principle by, among other things, the right to advocacy, nomination of named persons and advance statements (although where a patient is subject to compulsory measures a statement can be overruled).

The implementation of these provisions has not been without problems and we outline these below. The recent McManus review of the Scottish Act<sup>16</sup> made further suggestions.

*Substitute decision-maker:* Under the Szmukler *et al* draft bill, the substitute decision maker (SDM) plays a vital role. This defaults to the primary carer if one has not been appointed and the patient does not

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13 Department of Health 1999, Report of the Expert Committee Review of the Mental Health Act 1983, para 5.97.

14 *Ibid.*

15 Funded by the Nuffield Foundation: An exploration of the

understanding and use of the 'impaired ability' criteria for compulsory treatment in the Mental Health (Care and Treatment) (Scotland) Act 2003.

16 Published August 2009  
[www.scotland.gov.uk/Publication/2009/08/07143902/0](http://www.scotland.gov.uk/Publication/2009/08/07143902/0).

object, although if she lacks capacity at the time, it may not be clear whether she objects or not. The primary carer is consulted at various times in the provision of care and it is not clear what role she might have in a tribunal.

There is a clear potential for conflict of interest. The named person provision in Scotland, whilst flawed, does allow that person to represent her own views and not those of the patient. It is not clear who would be appointed the SDM by a tribunal where one does not exist.

The default position in Scotland has caused some concern, as have the responsibilities of the named person<sup>17</sup>. If it is intended that this work through a list of next of kin, there needs to be provision for a patient to make a blanket refusal of any nominated person, an issue which has been raised during the review of the law in Scotland<sup>18</sup>.

In such cases, the necessity of the SDM role reverting to a public agency may be considered, as there will be three different scenarios: where a person never has had capacity, where a person who had capacity has lost it and will not regain it and a person with fluctuating capacity.

*Independent advocates* If advocates are to be 'instructed' to represent a patient, it is not clear when this is done or by whom. If it falls to the tribunal, the problem of interim hearings will arise, as the advocate seeks time to consult with the patient.

The draft bill is perhaps somewhat unclear how far the advocate is following her own agenda on behalf of the patient, rather than simply representing the patient's wishes<sup>19</sup>. Neither is it clear whether a patient can refuse the services of an advocate, particularly if she wishes to engage a lawyer. The resource implications of all patients at a tribunal having to have an advocate are considerable, and the Scottish experience could prove instructive.

*Advance directives* As described in the draft bill, advance directives have a narrow role, which is only to refuse certain interventions. Most mental health advance directives allow a person to consent to particular treatments as well as refuse, and many states in the USA allow for the appointment of a proxy decision maker<sup>20</sup>.

Although there is general agreement that a patient cannot 'demand' a certain treatment, many people with recurrent illness which affects their capacity find it helpful to outline their preferred course of treatment at such times, as well as wider issues around treatment and management. It is the wider issues which seem of particular interest to many in Scotland<sup>21</sup>.

Szmukler *et al* suggest that '*Such decisions may still be overridden when treatment without the consent of the person is expressly authorised by the Act*'. This suggestion, which would be weaker than the Scottish position<sup>22</sup>, will lead many who would otherwise consider making an advance directive to question their value. It raises questions as to whether the overruling of an advance directive only applies to a recurrent mental illness or may apply to other advance refusals of treatment.

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17 Berzins KM, Atkinson JM. (2009) 'Service Users' and carers' views of the Named Person provisions under the Mental Health (Care and Treatment) (Scotland) Act 2003' *Journal of Mental Health* 18 207–215. Berzins K.M., Atkinson J.M. (submitted) 'Perceptions of policy influencers and mental health officers of the Named Person provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003.'

18 See n.16 above.

19 At clauses 52(1)(d) and (e) of the draft bill.

20 For example, New York and Massachusetts.

21 Reilly J, Atkinson JM (submitted) 'The content of mental health advance directives: advance statements in Scotland'.

22 Where those authorising or exercising compulsory powers must 'have regard' to any advance statement and report any overriding of a statement to the Mental Welfare Commission. MH(CT)(S)A 2003, ss275, 276.

If the advance refusal is upheld, consideration still needs to be given to whether a person can or should be detained (for her own or other's safety) and not treated. If advance and current capacitous decisions are to be treated equally, then maybe treatment and detention must be considered separately, where it is possible to refuse treatment, but not detention. The issue is then whether it is appropriate to detain someone because of risk, and whether the level of risk to self or others is the same to warrant detention. The ramifications of this are considerable.

## Practicalities

Whilst practicalities should not stand in the way of safeguarding people's rights, the opportunity cost attaching to them must be considered.

Tribunals, although welcomed in Scotland, have also caused the most concern, mainly over their demand on resources, ranging from medical time (each tribunal requires two doctors) to the comparatively high involvement of legal representation at hearings, with consequences for the legal aid budget and a perceived contribution to an unacceptably high number of interim hearings<sup>23</sup>.

An estimate is needed of the number of additional tribunals likely as a result of including treatment for physical conditions as well as mental disorders. A tribunal may be less threatening than a court, but in England family courts have a record of thoughtful decision-making and may be more appropriate for decisions such as end of life decisions or sterilization. We have seen similar trends in Scotland.

Where a tribunal is appropriate, it is not clear how quickly one can be requested and then held, for example, to deal with an end of life decision.

While the *Adults with Incapacity Act* was passing through the Scottish Parliament, campaigners urged that the safeguards on medical treatment for informal patients lacking capacity, whether in hospital or nursing homes, should mirror mental health act safeguards. The government argued that the resource implications made this impractical. However we would welcome such safeguards. Without them there is no check on the appropriateness of treatment such as the use of anti-psychotic medication. This has been a problem in Scotland and elsewhere<sup>24</sup>.

## Forensic issues

While importing the capacity approach to the criminal justice system is logically attractive, we have some concerns about its impact in practice. Scotland has not adopted this approach. If the courts decide that an offender has a mental disorder, that she could benefit from treatment and that this is the most appropriate disposal, it may make an order whether or not the person consents and whether or not she has the ability to consent<sup>25</sup>. It may, of course, pass no sentence or a lesser sentence (such as probation) where a person agrees to treatment.

It could be argued that this approach threatens the ethical principle of respect for the patient's autonomy, which is at the heart of the capacity test. However a person who has been convicted of a crime (or who

23 F Dobbie, S Reid and others 'An exploration of the early operation of the Mental Health Tribunal for Scotland' Scottish Centre for Social Research (2009).

24 Ballard C, Lana MM, Theodoulou M, Douglas S, McShane R, et al. (2008) 'A Randomised, Blinded, Placebo-Controlled Trial in Dementia Patients Continuing

or Stopping Neuroleptics' (The DART-AD Trial) . *PLoS Med* 5(4): e76. Prentice N et al (2002) presented at Royal College of Psychiatrists Old Age Section Annual Residential Meeting.

25 *Criminal Procedure (Scotland) Act 1995, (as amended)* s57A(3).

has been found not guilty by reason of insanity) has already compromised her autonomy. These are not discriminatory provisions. A person with no mental disorder may similarly face detention in prison.

On the other hand, insofar as the suggestions from Szmukler *et al* reflect the principle of minimum necessary intervention, they require serious consideration. Could a hospital direction contain two strands: compulsory detention in hospital linked to a prison sentence, or voluntary admission to hospital linked to a prison sentence? Why should not prisons be able to transfer a prisoner to hospital where she agrees the need for treatment? The current provisions appear to discriminate against prisoners with mental health needs. If a prisoner has a physical health need, she will be treated voluntarily, unless she is incapable of taking the decision in question. The same should apply to prisoners with mental health needs, who should not become subject to mental health act provisions unless these are otherwise appropriate.

Other proposals appear somewhat more controversial. Should a capable person be able to refuse remand for psychiatric reports? And how is her capacity to refuse to be measured without such reports? If a person's mental disorder means that prison staff are unable to care for her, is it appropriate for her to be able to refuse a transfer to hospital, on the grounds that only she has the capacity to make the decision?

Any new legislation will involve a balancing of competing ethical priorities, and each jurisdiction must set the scales where it seems appropriate. We can only say that we do not think an approach based solely on capacity would be acceptable in Scotland.

Finally, Scotland has effectively reduced one important area of discrimination in the criminal justice system. Following the recommendations of the MacLean Committee<sup>26</sup>, where a person has committed a serious, violent or sexual offence, the court may impose an order for lifelong restriction. This means that decisions about the person's discharge are subject to risk assessment by the Risk Management Authority, whose remit covers both those with and without mental disorders<sup>27</sup>. We welcome this approach, which singles out risk, rather than diagnosis, as the basis of decision-making.

## Conclusion

Szmukler, Daw and Dawson have shown that a fused capacity law is possible, at least in the field of medical decision-making. While points of detail or emphasis may vary, this ambitious paper gives us a useful opportunity to discuss the form and purpose of mental health and incapacity law.

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<sup>26</sup> *Report of the Committee on Serious Violent and Sexual Offenders, Scottish Executive (2000).*

<sup>27</sup> CP(S)A 1995, s210F.