

Reviewing Scottish Mental Health Law: Any Lessons for England and Wales?

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Introduction

This article looks at the Millan Committee's review of Scottish mental health law, with some reference to the work of the Richardson Committee¹ and the Government's response to it². Whilst the issues raised were similar, the Scottish approach is likely to differ in certain significant respects. It is hoped that the article will, therefore, add to the debate south of the Border.

Remit of Millan Committee

The Millan Committee was appointed in February 1999 to undertake a comprehensive review of the Mental Health (Scotland) Act 1984. Its chairman is the Rt Hon Bruce Millan, a former Secretary of State for Scotland and European Commissioner. Members of the Committee include the usual psychiatrists, nurses, social workers, lawyers and representatives of voluntary organisations and also, unlike Richardson, user and carer representatives.

The Committee has taken evidence from a wide range of groups and individuals and has carried out separate consultation processes with users, carers and people with learning disabilities. Like Richardson, however, our work has been made more difficult by the short time frame within which we had to operate, just over 18 months for a fundamental review of legislation last reviewed in the 1960s. (It is instructive to note that the Percy Commission³ took four years to reach its conclusions.)

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1 The expert committee chaired by Professor Geneva Richardson whose Review of the Mental Health Act 1983 ('the Richardson Report') was published in November 1999.

2 *Reform of the Mental Health Act 1983- Proposals for Consultation* (1999) The Stationery Office.

3 The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, whose report [(1957; Lord Percy) Cmnd 169, HMSO, London] led to the 1959 Mental Health Act for England and Wales and the 1960 Act in Scotland.

The Committee will be issuing its final report early in 2001 and this article cannot pre-empt its conclusions, but it may be instructive to indicate key areas of concern, particularly where the Committee appears to be diverging from Richardson.

Those key areas are: capacity and the grounds for compulsion, compulsory treatment in the community, protection for voluntary patients, whether learning disability should be included in mental health legislation and advance directives.

Incapacity as a ground for compulsory intervention

The Mental Health (Scotland) Act 1984, like its English equivalent, sets out a series of tests which must be satisfied before a person can be admitted to hospital. Unlike England and Wales, before a long term order can be made, the forum, in this case the sheriff court, has to approve the order. (Both Richardson and the Government appear to have accepted that the Scottish system is preferable, for human rights reasons.) A sheriff can make an order only if satisfied that

- The patient has a mental disorder ('the diagnosis test')
- The disorder is such that it is appropriate for the patient to be treated as an in-patient in hospital ('the appropriateness test')
- The patient needs treatment in the interests of his or her own health or safety or for the protection of other persons ('the risk test') and
- Such treatment cannot be provided unless compulsory measures are used ('the justification test')⁴.

If the sheriff is not satisfied as to any one of these elements, a long term order cannot be made.

The Committee's greatest concern was over the appropriateness test. The other tests contain a measure of objectivity which can be challenged by a patient opposing an order. The patient can obtain independent psychiatric reports to challenge the diagnosis test, and can challenge risk assessments made by the doctors⁵. Evidence from social workers or others can be obtained which can demonstrate that there are alternatives to detention in hospital and that the justification test has not been satisfied.

The appropriateness test is less transparent. Leaving aside its automatic linking of compulsion with hospitalisation, which may no longer be appropriate if a principle of minimum necessary intervention is accepted, the test is still flawed. It is based on the doctor's professional judgement that hospital care is necessary, without making explicit the grounds on which the doctor is to reach that decision. All the patient can do is obtain another doctor's opinion stating that hospital is not appropriate. As it is the first doctor who will remain responsible for the continuing care of the patient, the sheriff is likely to give greater weight to her assessment of the patient's needs.

The appropriateness test met with little approval on our first consultation, and many respondents urged the Committee to look at a capacity test to replace it. It was argued that lack of capacity was, in fact, the reason why doctors felt it appropriate to take compulsory measures in particular cases. Lack of capacity was the ethical justifications for the law's discrimination against people with

⁴ *Mental Health (Scotland) Act 1984, s17(1).*

⁵ *Although work needs to be done in making risk assessments more transparent and improving the quality*

of evidence brought before the sheriff - often no more than hearsay.

mental disorders. It was the reason why they were singled out from other patients and could, in certain circumstances, be compelled to receive treatment against their will. A mental disorder can so incapacitate someone that they lose their own autonomy. Society then has a duty to intervene to protect the patient. An inevitable corollary of this principle is that so long as the patient does retain capacity (however impaired) they should be able to take their own decisions, however unwise, in the same way that non-mentally ill people are able to take unwise and irrational medical decisions⁶.

The Committee is still considering the place a capacity test should have in Scots law. There is concern to deconstruct the basis on which doctors make decisions about whether compulsory measures are appropriate and a desire to ensure that the new law has a firm ethical base (not least to comply with ECHR obligations). However there is also concern that lack of capacity may not be the appropriate test to use when determining whether a person should be subject to compulsory measures.

Capacity fluctuates. Is it appropriate that a person should be free to discharge himself from hospital on a day when he is not delusional even if doctors suspect that the next day he will be very different? Capacity, or lack of it, is very difficult to diagnose. (Delegates at our specialist dementia seminar explained how fluid a concept capacity was, requiring observation of the patient over a period of time, with a multi-disciplinary input into the assessment.)

The test in the new Act would have to be functional. A doctor would have to certify that the patient was unable to take medical decisions relating to her mental disorder, because of the mental disorder. The fact that a decision was unwise could not, of itself, lead to a conclusion that the patient lacked capacity; as this would violate the non discrimination principle. Clearly the fact that the patient was rejecting the help offered might be an indication of his mental disorder. However concern was expressed that a patient might be held to 'fail' the capacity test simply because he or she disagreed with what the doctors recommended.

Any capacity test would need to be widely interpreted, and would need to include all the so-called Eastman elements⁷ (inability to take a decision, to communicate, to understand information, to understand that one was ill or to make a true choice). However there was concern that there could still be people who were ill, who needed help and yet who might fail to receive the help they needed because they 'passed' the capacity test. To some of the Committee the capacity test seemed unduly legalistic, promoting autonomy (or apparent autonomy) at the expense of the equally important ethical principle of beneficence. Richardson recognised this dilemma and suggested that the decision as to whether there should be an exception to the general rule in this situation was a matter for the politicians⁸. The Millan Committee is likely to go further and attempt to produce a formula which recognises the ethical attractions of the capacity test but tempers this with a common sense and pragmatic approach.

6 See *Sidaway v Governors of Bethlem Royal Hospital* [1985] AAC 871 per Lord Templeman. A patient who has capacity is entitled to reject the doctor's advice 'for reasons which are rational or irrational, or for no reason'.

7 As discussed in *Re C (Mental Patient: Medical Treatment)* (1993) 15 BMLR 77.

8 Richardson Report, paras 2.10 and 7.23.

We have tried to consider what it is about mental disorder that should justify special treatment under the law. [While a mental disorder can affect cognition, one of the elements in a capacity test, its effect is more than that.] Feeling, emotion, judgement, all may be impaired. A person may know that they are ill but be compelled by their illness to reject treatment (the true choice test).

There was some feeling in the Committee that the criteria for the use of compulsory measures should be the patient's impaired judgement rather than his or her lack of capacity.

The distinction between impaired judgement and lack of capacity is subtle, but important. 'Impaired judgement', unlike incapacity, is not a legal term of art. If included in a statute, the words would be given their ordinary meaning. The test says that it should not be possible to take compulsory measures in the life of a person who has a mental illness, if their decision making ability in relation to treatments for that illness is unaffected by the illness. But if the illness has distorted the person's ability to decide on treatments, the person should be given the benefit of medical treatment and support. The test is perhaps less legalistic than the incapacity test. It might be closer to the decisions which psychiatrists actually make on the ground. It might also be less stigmatising for those who are found to need compulsory measures.

The distinction between incapacity and impaired judgement may be seen more clearly in the light of some case studies. Impaired judgement (i.e. judgement impaired because of the mental disorder) would be seen in Richardson's depressed housewife who thought life was not worth living⁹, in the young woman with anorexia who does not accept she is dying and in the delusional patient who thinks the doctors are trying to poison him or her. While the second two would probably also lack legal capacity, the first might not. However the person with schizophrenia who knows they are ill but who wants to try to live drug free would not be caught. The doctors might not agree with their decision, but if it was made with full understanding of the facts and possible risks, they would have to respect it. Even if the patient's decision was unwise, it would not be the mental disorder which distorted it.

Whether the Millan Committee ultimately decides on a strict capacity test or prefers the impaired judgement criterion may have little effect in practice on the number of people subject to compulsory measures under the Scottish legislation. Research in certain US States which introduced narrow 'dangerousness' criteria into their mental health legislation showed that, while commitment rates dropped immediately after the introduction of the new legislation, they then rose to previous levels. Commenting on this trend the researcher wrote that

*'When the results of a law narrowly applied will be contrary to the moral intuitions of [those applying the law] they will act at the margins to modify the law in practice to achieve what seem to them to be more reasonable outcomes.'*¹⁰

The Millan Committee's deliberations are based on this common sense approach: attempting to find solutions which reflect the innate common sense of those operating the law and those who may be subject to its provisions, but which also have a firm ethical foundation.

9 Richardson Report, para 7.9ii.

10 Applebaum, PS (1997) *Almost a revolution: an international perspective on the law of involuntary*

commitment Journal of the American Academy of Psychiatry and the Law 25, 135-147.

Compulsory treatment in the community

Unlike Richardson, Millan's remit did not include a requirement that it should find a method of introducing compulsory treatment in the community (CTOs). Hostility to such orders has been strongly expressed in Scotland by, among others, the Scottish Association for Mental Health (similar to MIND south of the border) and the Scottish Users' Network (SUN). However despite the arguments against CTOs, there are also powerful reasons to suggest that some kinds of compulsory measure should be available outside a hospital setting.

The Committee has yet to reach a final decision, but is giving serious consideration to removing the automatic linking of compulsion with hospitalisation. There are several reasons for this.

First, the principle of least restrictive and invasive intervention means that, if a person can be adequately and appropriately helped without requiring in-patient treatment, this should be offered. This should not be at the expense of a proper care plan, looking at the person's needs for health and social supports, however. Treatment should mean more than just medication and any care plan should be approved by the forum and subject to review by them. (Some people who are so ill as to require compulsory measures may, in fact, regard hospital as a less restrictive option. Any new law should allow their wishes to be respected.)

Secondly, while closure of long stay hospitals has taken place more slowly in Scotland than in England and Wales, all the trends are in the direction of community based services. To link compulsion to bricks and mortar rather than to appropriate services might, it was argued, render a new Act obsolete almost from its inception.

Thirdly, the Committee was made very aware of the conditions in our acute psychiatric wards. Successive reports from the Scottish Health Advisory Service have highlighted the strains under which the system is operating. Many of those opposing CTOs (the present author included) did so on the assumption that patients receiving compulsory care in hospital could be guaranteed a certain standard of care and support. That assumption can no longer be made. Provided reciprocity (another principle the Committee is moving towards) is accepted, a patient may receive a better standard of care in the community, with less disruption to their lives.

The Committee does not, however, believe that community orders on their own will solve the problems of those patients with whom services find it difficult to engage. Patients may be required to live in a certain place or to accept forms of medical treatment, but if they are not convinced that services can help them, they will simply vanish. Assertive outreach and new ways of trying to engage with patients are needed.

Informal patients

Another major concern for the Committee was the protection of voluntary patients, some of whom told us that they were only in hospital because they had been told that they would be sectioned if they attempted to leave. How can the law protect these patients?

Some of those coming from a civil rights background would prefer the reluctant voluntary patient to be made subject to compulsory measures rather than stay in hospital under pressure. The detained patient can appeal against detention, have their treatment reviewed by a second opinion doctor and apply the Mental Welfare Commission for discharge. Better to be actually than *de facto* detained. On the other hand there was a strong feeling in the Committee that the principle that the

Act should not be used if a patient was willing to be admitted informally¹¹ was equally important. A patient who is sectioned has less freedom to negotiate with doctors than the so-called 'voluntary' patient, (perhaps more accurately described as an 'informal' patient) and there may be additional stigma in having been a detained patient.

Many of those who responded to our consultation said that voluntary patients needed extra protection. Clearly bullying a patient to stay in hospital or to accept medication is not acceptable. If a person is truly unwilling to stay, and doctors consider this necessary, formal procedures should be used. A revised and strengthened Code of Practice should make this clear.

However there is a distinction between bullying and information giving. In certain circumstances, if an ill patient asked doctors whether they were free to leave, it would be appropriate for them to be told that, although they were, doctors would use detention measures if they did try to go. It was hard to see a way of protecting patients against this apparent 'threat' so long as compulsion remains a part of mental health law.

The Law Society of Scotland suggested replacing the concept of medical consent with 'evident willingness' to accept the care or treatment proposed. It regarded consent as too passive, not fully recognising the patient as a partner in the medical decision making process. 'Evident willingness' is the term used in some continental systems and would not, it was felt, include the informal patient who clearly did not want to be in hospital or to accept the medication proposed.

Whilst some respondents to our consultation felt that specific legal safeguards needed to be put in place for informal patients, on the whole the feeling of the Committee has been against this. Rather it seems likely that the Committee will recommend general improvements overall to the Act which will strengthen the position of informal patients. Rights to advocacy, new principles stressing participation and respect for the patient's wishes, improved rights to information and a strengthened Code of Practice should improve practice and increase the ability of all patients to participate in their care and treatment.

Patients with incapacities

A sub-category of informal patients is those who, as in Bournemouth¹², are unable to take decisions about their treatment. Scotland now has its own incapacity legislation to protect such patients. Under the Adults with Incapacity (Scotland) Act 2000, if a patient is incapable¹³ of making medical decisions the doctors can do what is reasonable to promote or safeguard the patient's physical or mental health¹⁴. The wording clearly includes patients whose mental disorder makes them incapable of deciding about psychiatric treatment.

In Scottish psychiatric wards in the future there could, therefore, be patients all with similar diagnoses but with three different legal statuses: informal patients, detained patients and those being treated under the incapacity legislation.

11 A principle emphasised by the Percy Commission and found in s17(2) of the 1984 Act.

12 *R v Bournemouth Community and Mental Health NHS Trust, ex parte L* [1998] 3 AER 289.

13 A person is 'incapable' if he or she is incapable of acting, making or communicating decisions or of retaining the memory of decisions because of mental disorder. (Adults with Incapacity (Scotland) Act 2000, s1(6).)

14 *Ibid*, s47(2).

The new Act does not, however, allow doctors to admit a patient to a psychiatric hospital against their will¹⁵. If a patient lacking capacity appeared unwilling to go to hospital the Mental Health Act would have to be used. Nor does the Act allow detention¹⁶. If a person was *de facto* detained, as some of their Lordships thought the patient in Bournemouth was, the Mental Health Act should be used.

There has been some debate in Scotland about proposed new rules for medical treatment for mental disorder for patients with incapacities. New regulations will spell out the safeguards to be imposed for special treatments which fall outside the doctors' general authority to treat. It is thought, for example, that Court of Session approval will be required for non-therapeutic sterilisation of a mentally incapable woman (despite the fact that all other decisions about patients are to be taken by the lower, sheriff courts). More controversially, the Scottish Executive appears to be accepting the recommendations of a working group¹⁷ to extend psychosurgery to patients who are unable to agree to it, provided the need for the operation is confirmed by the Court of Session. (The working party argued that those patients most in need of this rare procedure might be the very ones least able to accept it, such as patients with depression so disabling that they lacked the legal capacity to take medical decisions on their own behalf.)

For the majority of patients, however, the argument is about the special treatments currently set out in s98 of the Mental Health (Scotland) Act, long term drug treatment and ECT. Many of those responding to the consultation argued that the protections for incapable patients should mirror those in the Mental Health (Scotland) Act for detained patients. ECT at any time and drug treatment for over three months should require approval by a second opinion psychiatrist appointed by the Mental Welfare Commission. Protection against inappropriate treatment is vitally important for the person with incapacities, who may even lack the capacity to complain about treatment received.

While the Scottish Executive appears to have accepted the argument in respect of ECT, there appears an unwillingness to extend the rules on long term drug treatments to those with mental incapacities. This appears to be on resource grounds. Many residents of nursing homes currently receive drugs for mental disorder prescribed by GPs and obtaining psychiatric approval of this prescribing would, it is felt, place too great a burden on already stretched services.

Yet evidence has indicated that the problem with medication prescribed to nursing home residents is not merely theoretical. An important study in Glasgow looked at nursing home residents in the south of the city and found that 24% of them were being prescribed the major neuroleptic drugs, and in 88% of these cases the researchers did not regard the drug as clinically appropriate¹⁸.

The Scottish Executive is waiting to publish its regulations until it receives the Millan Committee's report. The Millan Committee is considering whether mental health and incapacity legislation should be consolidated into one act. If it does, there are powerful arguments for requiring that the safeguards for special treatments should be the same for incapable patients as for those subject to compulsory measures.

15 *Ibid*, s47(7)(c).

16 *Ibid*, s47(7)(a).

17 Crag Working Group on Mental Illness Neurosurgery for mental disorder. *The Scottish Office July 1996*.

18 A McGrath, G Jackson (1996) *Survey of neuroleptic prescribing in residents of nursing homes in Glasgow* *BMJ*, 312, 611-612.

People with learning disabilities

As in England and Wales, the Scottish Mental Health Act includes in its remit people with learning disabilities, even though on the whole they are not ill and their disability cannot be 'cured'. There were powerful arguments on both sides about whether people with learning disabilities who were not otherwise mentally ill should be included within a mental health act. Currently about 170 people with learning disabilities in Scotland are detained under the Act, some because they are suffering from a mental illness but the majority because of 'abnormally aggressive or seriously irresponsible behaviour'¹⁹.

The Committee took evidence from New Zealand (unfortunately via a video link) which several years ago took learning disability out of its Mental Health Act. The result was that a significant number of people were discharged from hospital and no suitable accommodation was provided for them. Following the inevitable disruption, New Zealand is now introducing new legislation for people with learning disabilities, which will include the use of compulsory powers.

However the Committee heard pressing arguments for excluding learning disability from the legislation. It is not a mental illness and not, generally a medical problem at all. It is only included in the current act as an add-on to an act mainly dealing with the effects of serious mental illness. Only one provision was widely welcomed, that which imposes an unequivocal duty on local authorities to provide free day training and occupation for people with learning disabilities living in the community²⁰.

Whether learning disability remains in the Act or whether Millan recommends a fundamental review of the law following the Scottish Executive's new strategy for people with learning disabilities²¹, it is no longer acceptable for people with learning disabilities to be included in mental health legislation almost by default. The Act should be examined afresh to see what provisions are relevant to them and what are not. Discrete provisions incorporating rights to services, protection of vulnerable people and secure provision for those who might pose a risk to others, should be put in place.

Advance Directives

A major area of discussion was advance directives. When the Adults with Incapacity Bill was placed before the Scottish Parliament, the Scottish Executive found itself unable to take on the recommendations of the Scottish Law Commission in its Report on Incapable Adults²² that advance directives in health care be given legal force. The inevitable backlash from the Catholic Church and pro-life groups was one which the new Executive felt itself unable at that stage to withstand.

The Millan Committee will not seek to reopen that discussion, but it is considering the role of advance directives in psychiatric care. This is particularly relevant in the light of its likely recommendation that a new Act stresses the importance of patient participation in care decisions and respect for patients' wishes.

19 *Mental Health (Scotland) Act 1984, s17(1)(a)(ii)*.

20 *Mental Health (Scotland) Act 1984, s11*.

21 *The same as you? A review of services for people with learning disabilities The Scottish Executive June 2000*.

22 *Scot Law Com No 151, September 1995*.

Advance directives in psychiatry can take several forms. A patient may fill out a 'crisis card' naming people to contact in an emergency. The card may direct doctors to discuss the patient's care with the named person and may also specify types of treatment that the patient does or does not want. A patient may sign a 'contract' with their consultant setting out the terms of their discharge from hospital and the sort of conditions which might result in the patient being recalled. The contract might spell out the patient's preferences about future treatment. A patient might appoint another person her 'health care proxy' to take medical decisions on her behalf²³. Alternatively a person may go to their lawyer and sign a formal document along the lines of a 'living will' stating their treatment options in the event of future incapacity²⁴.

Many commentators think that even if advance directives are not legislated on, they are already legally binding. The BMA has given advice to doctors saying that doctors should recognise them²⁵. However an advance directive can be overruled if the patient is detained under the Mental Health Act. Doctors might take a directive into account when considering treatment options, but would be under no legal duty to do so.

Clearly from the patient's point of view, advance directives represent a way of reducing uncertainty about the future and of giving the patient more control over their lives. If drawn up in partnership with their doctor, they can represent a way of negotiating treatment options. Advance directives can reduce the powerlessness many patients feel when faced with the psychiatric system. They are a way of promoting patient autonomy.

From the doctor's point of view they can reduce the need for compulsion by persuading patients to agree the type of symptoms which might necessitate their readmission. Doctors are supposed to try to consider patient preference when deciding on treatment and the advance directive can help here. It has been shown that compliance with treatment is improved if patients understand the need for treatment and feel their views are listened to and respected.

Most of the respondents to the consultation appreciated these advantages, and most saw a place for advance directives in psychiatry. The dividing line was, perhaps predictably, over the legal effects of directives. While health care providers generally felt they should be persuasive only, social services and voluntary groups felt they should be legally binding.

Some respondents believed that a directive should be capable of being overruled if there was a serious risk to the patient's health or safety. Others (including some GPs and psychiatrists) felt that a properly drawn up advance directive, made by a patient who was well and in full possession of the facts, should be respected, even if the result was the patient's death. These respondents argued that the principle of non-discrimination (which means that generally the law should discriminate against mental health service users no more than strictly necessary) demanded no less. If a Jehovah's Witness is allowed to refuse a blood transfusion which could save his life, a mental health service user should be allowed make an advance refusal of treatment and to stipulate that this should apply even in life-threatening circumstances.

23 A limited form of health care proxy is incorporated in the Adults with Incapacity (Scotland) Act. (See ss 16 and 50(6).) The proxy's decisions can be overruled if the doctor obtains a second medical opinion.

24 A comprehensive (yet strangely intimidating) model is available from the Bazelon Center for Mental Health Law at www.bazelon.org/advdir.html.

25 Advance statements about medical treatment The British Medical Association 1995.

Whether the Millan Committee will accept this principled approach or will adopt a more pragmatic (and it could be argued compassionate) approach, the author will leave readers of this article to surmise.

Conclusion

Many of the discussions of the Millan Committee (on informal patients, learning disability and community treatment orders) mirrored those in England and Wales. The Scots were given longer to carry out their review and were, perhaps, therefore able to carry out a slightly more leisurely and comprehensive consultation process.

Incapacity legislation was passed in Scotland during the life of the Committee, and the Committee had to grapple with the complex issues of its interface with mental health legislation.

Unlike Richardson, the Committee's hands were not tied over the issue of community orders. If Millan does, in fact, recommend such an order, the Committee's final report may make interesting reading for those still involved in the debate.