

# Scottish Parliament acts on Mental Health Law Reform

*Hilary Patrick\**

## **Introduction**

The Mental Health (Care and Treatment) (Scotland) Act was passed by the Scottish Parliament on 20 March 2003 and received Royal Assent on 25 April 2003. The largest piece of legislation to pass through the Scottish Parliament, the Act represents a major reform of mental health legislation in Scotland. This article offers a short introduction and will serve as yet another example of how devolution is leading to major divergences in welfare law and practice north and south of the border.

## **Background**

The Act replaces the 1984 Mental Health (Scotland) Act, which is broadly similar to the Mental Health Act 1983 which applies in England and Wales.

The 1984 Act was reviewed by an expert committee chaired by the Rt. Hon. Bruce Millan, a former Secretary of State for Scotland<sup>1</sup>. Its report, *New Directions*<sup>2</sup> was the result of widespread consultation, including the holding of consultation events with a wide range of bodies and the taking of oral evidence.

The Scottish Executive, in its policy paper *Renewing Mental Health Law*<sup>3</sup>, broadly welcomed the Millan report, with some significant exceptions. Following a detailed scrutiny of the Bill by the Parliament's committees, notably the Health and Community Care Committee, major changes were made in the Committee stages of the Bill and the Act now broadly reflects the Millan recommendations.

---

\* Honorary Fellow, Faculty of Law, University of Edinburgh

1 See H Patrick, *Renewing Scottish Mental Health Law: Any lessons for England and Wales?* JMHL Dec 2000, p147–156.

2 *New directions: Report on the Review of the Mental Health (Scotland) Act 1984* Scottish Executive January 2001.

3 *Scottish Executive, September 2001.*

## Statement of principles

An interesting feature of the Act is its setting out of the principles which should apply whenever a person is carrying out functions under the Act. Some principles are set out in the Adults with Incapacity (Scotland) Act 2000 ('AWIA')<sup>4</sup> and in the Children (Scotland) Act 1995<sup>5</sup>, but the 2003 Act's statement of principles is considerably more comprehensive. The statement in the Act is intended to reflect the ten principles recommended by the Millan Committee and accepted by the Executive.

The principles are taken as representing accepted good practice. As such they are not controversial, but it is unusual to see such statements set out in full in legislation, albeit not as extensively as some campaigners would have wished.

As recommended by Millan, the principles are as follows. *Non-discrimination* – people with a mental disorder should, wherever possible, retain the same rights and entitlements as those with other health needs. *Equality* – powers under the Act should be exercised in a non-discriminatory manner. *Respect for diversity* complements this. Care and treatment offered should take into account users' age, gender, sexual orientation, ethnic group and social, cultural and religious background.

The important principle of *reciprocity* states that where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.

The principle of *informal care* recognises that wherever possible, care, treatment and support should be provided without recourse to compulsion. Any compulsion used should be the *least restrictive alternative*.

The *participation* principle attempts to ensure that service users are as fully involved as possible in all aspects of their assessment, care, treatment and support. *Respect for carers* is the corollary to this.

The Act mirrors the AWIA by including a principle of *benefit*. Any intervention under the Act should be likely to produce a benefit that cannot reasonably be achieved other than by the intervention. This is paralleled by the principle of *child welfare* – the welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act.

Many campaigners remain unhappy that the way in which the principles have been incorporated into the legislation has reduced their clarity and impact. However the principles have had a significant impact in shaping the form of the legislation. They will continue to be relevant in influencing the content of the Code of Practice which will flesh out the provisions of the Act.

## Introduction of Mental Health Tribunals

A new system of mental health tribunals (influenced by but different from MHRTs in England and Wales) will be introduced. These will replace the sheriff courts as the forum for dealing with applications for admission, appeals and variations of orders. As in England and Wales, there will be a legal chairperson, a medical member and a general member. Decisions will be by majority verdict. The controversial medical examination by the medical member will not be required. It is made clear that the general member may be appointed because of experience of mental health care gained as a user of services or a carer.

---

4 *Benefit, least restrictive alternative, taking account of adult's wishes and feelings, respect for views of relatives and carers and encouraging skills of adult where possible.*

5 *Welfare of child to be paramount.*

### **Criteria for compulsion**

The criteria for the use of compulsory measures are reformulated. Compulsory powers can be used only if there is a significant risk to the health, safety or welfare of the patient and if treatment is available which can prevent the patient's health from deteriorating or alleviate the symptoms or effects of the disorder.

While a strict incapacity test has not been imposed, compulsion can be used only if a patient's ability to take medical decisions is 'significantly impaired'. The criteria will also have to be read in conjunction with the principles, particularly those of benefit, informal care and least restrictive alternative.

### **Community treatment orders**

The Act contains a range of new orders, including, controversially, a community treatment order where this is appropriate and the least restrictive option. The Mental Welfare Commission will closely monitor the new orders. The Scottish Executive has retained the power to impose further conditions on the use of such orders if experience proves this is necessary.

In an attempt to reduce the number of emergency 72-hour admissions (against which there is no appeal under the 1984 Act) a new form of 28-day short-term detention straight from the community is introduced. Two doctors and the mental health officer, the equivalent of the approved social worker in England and Wales, must approve the new order.

### **New duties on health boards and local authorities**

New duties are imposed on health boards and local authorities. The duties to provide occupation and training for people with a learning disability and after-care (already wider than the duties in s117 of the Mental Health Act 1983) are replaced by wide duties to provide care and support services and to promote well being and social development. This includes the provision of recreational, training and employment services.

The Act also broadly gives effect to the Scottish Law Commission recommendations for the protection of vulnerable adults<sup>6</sup>, insofar as these relate to people with a mental disorder.

The Scottish Executive was initially reluctant to impose specific duties on health boards, which have general duties under the National Health Service (Scotland) Act 1978. However in the Parliament the Bill was amended to include a duty on health boards to provide age appropriate services for young people with mental disorders (whether or not they are subject to compulsory measures) and to provide mother and baby units for women with postnatal depression.

### **Right to advocacy**

Health boards and local authorities are given the duty to provide adequate advocacy services, including collective advocacy. Every person with a mental disorder in Scotland will have a right to such advocacy.

---

<sup>6</sup> *Vulnerable adults* Scottish Law Commission Report No 158, 1997.

### **Patient representation**

Users are given the right to nominate a 'named person' to act as their next of kin in mental health matters. This can be a family member, carer, friend or homosexual partner. This recommendation partly fulfils the UK government to reform the rules relating to nearest relatives following *JT v the United Kingdom*<sup>7</sup>.

### **Advance directives**

The Act gives some recognition to the concept of advance directives in psychiatry. Most commentators believe that advance directives in respect of treatment for physical disorders are legally binding in Scotland, although there is no case law to confirm this. Some bodies consulted by Millan argued that advance directives in psychiatry should also be legally binding, if validly made and applicable in the circumstances. A psychiatric advance directive made by a competent person should not, it was argued, be capable of being overruled by the compulsory powers in mental health legislation.

However neither Millan or the Scottish Executive was prepared to accept that the time was right for such a radical approach. Instead, the Act aims to encourage the use and development of advance directives, by requiring tribunals and mental health professionals to 'have regard' to their terms.

The tribunal must have regard to any advance directive when making an order. Doctors must take the terms of any advance directive into account when treating the patient or issuing a second opinion authorising treatment. If a patient is given treatment which conflicts with the terms of an advance directive, the doctor must notify the independent Mental Welfare Commission. The Commission will monitor the use of advance directives and has powers to stop treatments in certain circumstances.

### **Other treatment safeguards**

While many of the rules on compulsory treatments remain as in the 1984 Act (largely modelled on those in the 1983 Act), there are significant changes. Drug treatment given by the RMO without consent or second opinion can now be given for only two months, rather than three. ECT cannot be given to a competent patient who refuses the treatment.

Second opinions will be required for forced feeding and for other treatments as set out in regulations (likely to include polypharmacy and the use of drugs for a purpose other than that set out in the product's licence). If the patient is a young person a second opinion must be obtained from an expert in child and adolescent psychiatry.

Similar safeguards will extend to patients treated under the provisions of the Adults with Incapacity (Scotland) Act 2000, except, unfortunately, for the second opinion on long-term drug treatments. The Scottish Executive was advised that it would be unworkable to apply this safeguard to the many vulnerable people living in nursing and residential homes who might have qualified for protection.

---

<sup>7</sup> 1998, Application No. 26494/95. This is still a major concern south of the border. See *R v Secretary of State for Health ex parte M*, *The Times* 25 April 2003.

### **Reform of sexual offences**

The Act brings the law relating to sexual abuse of people with mental disorders up to date. There are two offences.

Sexual relationships between people with mental disorders (both mental illness and learning disability) and their professional carers are made a criminal offence, on the grounds that such relationships generally represent a breach of trust.

For other persons the relationship will be a criminal offence if the patient is unable to give a valid consent to the relationship because of his/her disorder or where there is use of fraud, deception, undue persuasion or deceit.

### **Secure provision**

The way in which the criminal courts deal with people with mental disorders is reformed and streamlined. Regulations will be made to replace the mainly common law powers of hospitals to search patients, monitor telephone calls, internet access et cetera. There is little case law in Scotland to justify such controls and clearer rules were thought necessary to comply with human rights law.

### **Appeal against level of security**

A major problem with services in Scotland is the lack of medium secure facilities. Most people requiring secure services in Scotland (and Northern Ireland) are housed in the high security State Hospital at Carstairs, Lanarkshire. One medium security hospital has recently been opened in Edinburgh, and others are promised.

However there are at any time around forty patients in the State Hospital who are regarded as 'entrapped', assessed by their care team as not needing the high security of the State Hospital but with nowhere suitable to go. The parents of one of these patients recently brought his situation to the attention of the Scottish Parliament, using its innovative petitions procedure<sup>8</sup>.

While the Scottish Executive was initially reluctant to allow such patients a right to appeal against the level of their security, it was forced to bow to pressure in the Parliament and such a right is now included in the Act. This should lead to increased pressure on health boards to develop medium secure facilities. While this section may not be implemented immediately, the Act provides that it will be introduced by 2006 at the latest.

### **Conclusion**

The Act builds largely on the work of the Millan Committee, and has been widely welcomed. As would be expected, the greatest area of concern is the operation of the new community treatment orders, which were generally (but not universally) opposed by the user movement. The new Act is expected to come into effect in early 2005.

The Act was subject to wide consultation and interested parties benefited from open access to

---

<sup>8</sup> Scottish Parliament Petition PE440. See Scottish Parliament Public Petitions Committee Official Report 15 January 2002, Column 1533.

officials and Parliament at all stages of the process. Its passage through the Parliament was a clear demonstration of the Parliament working at its best. While the 1984 Act might be regarded simply as a modification of the 1983 Act to meet the different legal and social care systems in Scotland, the 2003 Act can be regarded as a distinctively Scottish solution to a Scottish problem.