REVIEW OF LITERATURE RELATING TO MENTAL HEALTH LEGISLATION

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EXECUTIVE SUMMARY

CHAPTER 1 REVIEW METHODOLOGY

The aim of the review was to identify and report on the literature relating to mental health legislation, as it might be relevant to discussions of reform of the legislation. Other literature informed some of the sections but the search was limited to that involving the law.

CHAPTER 2 OVERARCHING PRINCIPLES

The legal justifications for civil commitment are protection of the public and public responsibility. These allow persons to be detained both for their own protection and the protection of others. There are broad underlying principles to compulsory detention which have been suggested: dangerousness, due process, treatability and reciprocity.

Dangerousness and due process underpin American mental health legislation. Dangerousness as the criteria for detention has had less impact than was expected on detention because self-neglect, and welfare considerations, remain important. Dangerousness is a feature of a substantial number of detentions in Britain.

Due process is particularly important in the USA, in large part as a result of the civil rights movement. The role of the court is to ensure ‘fairness’ and to be independent. There is evidence from both Britain and the USA that both the courts and clinicians make ‘common sense’ judgements about who needs to be detained. They frequently act in what they believe to be ‘the person’s best interests’, interpreting the law in ways that allow such decisions to be taken. There is evidence that the short-term effects of changes to the law diminish and that previous patterns of decision-making re-establish themselves.

Treatability has been proposed as an underlying principle of mental health law. Treatability is often seen only in terms of medication and co-operation with treatment remains an issue in other forms of treatment such as psychotherapy. This is of particular relevance to people with a diagnosis of personality disorder.

Reciprocity is still to be fully explored as an underlying principle but includes concepts such as equality of treatment and the provision of ‘the best’ in terms of services, and treatment in compensation for removing a person’s liberty.
CHAPTER 3 DEFINITIONS OF MENTAL ILLNESS

Although mental illness or mental handicap (learning disability) may be necessary conditions for detention they are never sufficient conditions. Other factors, such as dangerousness or treatability (discussed above) are also necessary. These and other factors may broaden or restrict the number of people to whom the law applies. Availability of services may influence this as well as issues of civil liberties.

Some legislation has introduced specific diagnoses into parts of the Act with attendant problems. New South Wales, for example, allows the detention of a financially irresponsible person with a diagnosis of manic depression but not schizophrenia.

Most legislation has exclusion criteria, such as illegal or immoral conduct, religious or philosophical beliefs or opinions, sexual preference or orientation, promiscuity and the use of alcohol or drugs.

CHAPTER 4 COMMUNITY DETENTION

The main debate in community detention is between orders which allow for enforced treatment (usually medication) while someone lives in the community and orders which do not.

Community treatment orders (CTOs) have been challenged as an infringement of a person’s civil liberty and as problematic under Article 5.1 of the European Convention on Human Rights. Other arguments put forward against CTOs are that they are a response to a political agenda rather than clinical argument, that they turn staff into ‘parole agents’, that they may put staff at more risk, that people may be kept on CTOs for unacceptably long periods of time, and that problems with enforcement and sanctions make them unworkable.

Even where CTOs exist (such as in most of the USA and Australia) what sanctions can be imposed on patients on a CTO who still refuse treatment, beyond readmitting them to hospital, is unclear. Where there is data there is some suggestion that CTOs were not enforced or there were problems with enforcement when a patient refused treatment.

The impact of CTOs is difficult to establish as there is little good research. Their effectiveness cannot be divorced from the adequacy of community services and generally CTOs have been introduced with no additional resources. CTOs may be used to prioritise patients for services and there is some suggestion that it was increased use of services which accounted for improved outcomes rather than community detention per se.

Patients who are put on a CTO are likely (according to Australian research) to be non-compliant with medication in the community, and this might affect 3%-5% of in-patients.
In Britain leave of absence (LOA) has operated as a *de facto* CTO. It was limited to 12 months in Scotland by the Mental Health (Patients in the Community) Act. It had previously been limited to six months in England & Wales and this was extended to 12 months. Evidence from studies on LOA which go back to the 1980s need to be interpreted with care, since community services have changed considerably since then. Patients who were placed on LOA were more likely to have a recent history of dangerousness, be non-compliant with medication, have a recent history of loss to follow-up and have had more formal detentions than patients not on LOA.

Most (60%) LOAs were allowed to expire, 19% were formally discharged and 2% by a MHRT decision in England. Being recalled to hospital was most likely to be linked to non-compliance with medication. Outcome from LOA is variable with it seeming to improve outcome for about half the patients on LOA but an increase in admissions for about 20%. It is not a universal answer to poor compliance in the community.

The numbers of people on extended LOA in Scotland prior to their time limitation was steadily increasing. Services for people on extended LOA appear limited.

The 1995 legislation introduced supervised discharge (SD) in England and Wales and community care orders (CCOs) in Scotland. Supervised discharge was predated by the supervision register.

The number of people on a CCO in Scotland is small, although the number is slowly increasing. This may reflect opposition to their introduction by psychiatrists in Scotland. This was based on their lack of power to compel compliance with treatment. CCOs are seen as bureaucratic. There is concern that health boards or local authorities could be held liable in the event of not providing services or therapies laid down as conditions of a CCO.

Supervised discharge has been used predominately for male patients with a diagnosis of schizophrenia. Supervised discharge was used more by psychiatrists in general, forensic and rehabilitation settings than by old age psychiatrists. All supervised discharge orders surveyed had a condition relating to compliance with medication, 50% conditions about residence and 59% conditions about allowing access to supervisors.

**CHAPTER 5 GUARDIANSHIP**

The numbers of people on guardianship in Scotland has remained fairly constant for people with a learning disability, but has increased steadily for people with mental illness, dementia, pre-senile dementia and alcohol-related brain damage (Korsakov’s psychosis). For elderly people guardianship orders are frequently being used as a means of transferring people into residential care. Local authority guardians are often not clearly identified and this creates a
lack of clarity in respect of their powers and responsibility. Few people are represented by a curator ad litem.

A similar increase in the use of guardianship is shown in England. There is concern that some social services departments are not using guardianship due to lack of resources. It has been noted that guardianship may be preferred by Responsible Medical Officers (RMOs) to supervised discharge since initiation of guardianship is the responsibility of the approved social worker (ASW) whereas supervised discharge is the responsibility of the RMO.

Elsewhere guardianship exists in various forms. The hogosha system in Japan places great responsibility on the guardian to protect the community from the patient and is criticised both for this and its infringement of patients’ rights. Conservatorship in the USA is based on substituted consent, which is also the model used in a number of states in Australia. It is a model which is increasingly being used as a protective system for people with disabilities other than mental illness. Similar to this is the system of decision making by proxy established in New Zealand. This is also used for a wide range of people who are deemed to lack competency. It incorporates the principle of least restrictive alternative as does Canada’s model of guardianship which includes substituted consent.

CHAPTER 6 DETENTION IN SCOTLAND

Knowledge about detention and patients’ rights by patients, psychiatrists or GPs is generally poor. This includes doctors’ knowledge of their duty to inform patients of their rights, issues of consent and understanding of particular sections of the Mental Health Act.

Despite section 18 being intended as the main route to detention it is rarely implemented direct from the community. Emergency admission under sections 24 and 25 predominates. This is in contrast to England. Section 18 is seen as inappropriate or burdensome by GPs. Since a significant proportion of emergency detentions result in discharges to voluntary status there is concern that voluntary admission is not sought as rigorously as it might be.

Detention under all sections of the Mental Health (Scotland) Act continues to rise steadily.

CHAPTER 7 SECURE PROVISION IN SCOTLAND

There are a number of concerns regarding the provision of secure accommodation across Scotland. Facilities are variable as is level of security. Facilities for women are sometimes inadequate, particularly where hospitals are contracting. Most patients admitted to intensive psychiatric care units are male with a diagnosis of schizophrenia and a history of physical violence to others.
A particular problem at the State hospital is entrapment due to lack of medium secure facilities, with some patients being admitted there who are not in need of maximum security. The population of the State hospital continues to grow.

CHAPTER 8 MORTALITY AND MORBIDITY IN SCOTLAND

The number of suicides reported to the MWC continues to increase, and comes mainly from an increase in men and outpatients, the numbers for women and in-patients remaining constant. The dominant diagnosis is schizophrenia. The MWC recommends greater standardisation of procedures and risk communication.

There has been a dramatic rise in first psychiatric admissions for young men with a diagnosis of paranoid states, non-organic psychosis and, to a lesser extent, affective disorders. This may be linked to a greater incidence of substance abuse.

CHAPTER 9 ELECTROCONVULSIVE THERAPY

One small study found no difference between consenting and non-consenting patients and formal and informal patients in their perception of ECT’s helpfulness and their willingness to repeat the treatment.

In Britain ECT can be given to non-consenting patients. This is not the case everywhere. In New South Wales, for example, it can only be given to a non-consenting patient if it is considered to be immediately necessary as a life saving measure.

CHAPTER 10 VOLUNTARY PATIENTS

Voluntary patients do not have the same rights as detained patients to information or recourse to the safeguards provided by the Act. This is important given that many informal patients do not know their rights, including their right to leave hospital and to refuse medication. Where a patient seeks to discharge him/herself against medical advice, current mental state is a more important factor than what has happened to the patient in the past.

There is concern in Britain and elsewhere about the hospitalisation and treatment of patients who lack capacity but who do not object to treatment. The new legislation on incapacity in Scotland addresses some of these concerns. The majority of psychiatrists agree that lack of safeguards for this patient group is a problem. Although the number of patients being formally detained rose slowly after the Bournewood case this trend has stopped and detentions have
returned to previous levels. There appears still to be confusion over the treatment of incapable but non-objecting patients.

**CHAPTER 11 PATIENTS’ RIGHTS**

Different countries base issues of patients’ rights on their individual legislation or constitution, e.g. the American Constitution, Canada’s Charter of Rights and the European Convention on Human Rights. Articles 3, 5 (1)(e), 5(4), 12 and 13 of the ECHR are thought to be particularly relevant.

One ‘right’ argued for is the right to treatment or services. This is generally underpinned by an assumption that people want to be ‘well’. Without appropriate treatment a patient may be detained for a longer period (if then allowed to refuse treatment although detained). It is argued that this is not in the patient’s best interests. It is also expensive for the service.

A number of States and countries allow patients to refuse treatment when they are detained. This has been argued for under a variety of ‘rights’, including freedom of thought, freedom of religion, individual privacy, autonomy, bodily integrity and informed consent. Pragmatically, the right of refusal is often overruled and treatment is permitted, particularly where a patient has been violent.

**CHAPTER 12 CAPACITY, COMPETENCY AND CONSENT**

This section only deals with these issues in relation to people with mental illness.

In Britain the Mental Health Act allows competent people who have a mental illness to be treated against their will. There is a balance to be struck between the right to freedom of decision making and the right to protection from harm.

There is no single operationalised standard of competency. Tests of capacity seek to establish a threshold. The main approaches to defining capacity are: outcome, status and function, or some integration of these. The main characteristics of capacity are communicating a choice, understanding relevant information, retaining information, understanding/appreciating the personal significance of the information and arriving at a decision through reasonable and rational manipulation of the information. Tests of capacity need to be related to specific situations and cannot be applied generically.

There is some confusion between concepts of lack of insight and competency. Lack of insight seems to be equated with lack of appreciation of the personal significance of information for
most practical purposes. In common law, irrationality is not, in and of itself, indicative of incapacity. In assessing rationality it is difficult to separate the decision from outcome.

The MacArthur Treatment Competency Study was an attempt to develop a reliable and valid way of addressing competency in people with a mental illness, that would be useful both in relation to clinical and policy questions. The measures developed were not intended to be used as legal definitions of competency. It found that although patients with a mental illness performed less well than other groups, and people with schizophrenia less well than other groups of psychiatric patients, the majority of people with schizophrenia did not perform more poorly in competent decision making than other groups of people. The study highlighted the heterogeneity of people with a mental illness and raised a number of questions regarding the measurement of competency in people with a mental illness.

CHAPTER 13 MINORITY GROUPS

A number of groups are singled out for special consideration under mental health legislation.

The elderly population with senile dementia is seen as presenting special problems not addressed fully by the UK Mental Health Acts. Section 47 of the National Assistance Act 1948 does not have the same safeguards as mental health law. Ninety per cent of the people for whom it is used are over 65 years, in poor physical health and have a psychiatric disorder. Few Mental Health Review Tribunals are held in England for people over 65 years who are formally detained. The possibility of conducting hearings for the elderly along the lines of Children’s Hearings has been supported by some groups. Detention increases for women with age.

The Mental Health Acts refer to ‘mental impairment’, rather than mental handicap, in relation to guardianship, and there is some suggestion that this may have limited its use. Patients with a diagnosis of learning disability who are detained are likely to be young, male and detained for violent or challenging behaviour. Patients with a diagnosis of learning disability are likely to be detained for a longer period of time than patients with a mental illness.

There are problems in commenting on the use of mental health law in relation to ethnic minorities as there is little monitoring of ethnicity at key points in the criminal justice system and by the statutory bodies such as the MWC.

There is almost no research or data in relation to mental health legislation and homelessness.

CHAPTER 14 ATTITUDES TO PSYCHIATRIC ILLNESS
Some limited research was found relating to attitudes to people with mental illness in Scotland. A small survey of the public in Lothian, using vignettes, suggested that people with schizophrenia were treated similarly to a healthy control whereas people with depression or diabetes were treated more positively. Fewer people knew someone with schizophrenia than the other illnesses, but those who did know someone with schizophrenia were less likely to be sympathetic or sociable towards the hypothetical neighbour.

A similar finding was uncovered in a study of the media, which also demonstrated that people with a psychiatric illness are viewed as violent, even when this is contrary to experience.

Surveys indicate that GPs were less willing to treat people with schizophrenia than other illnesses and suggested that patients with a psychotic illness expected to be subject to more discrimination from GPs and psychiatrists than from the general public.

Although there is often local community opposition to facilities being sited in a particular area, there is some evidence that central planning control and a low key approach to the development of supported accommodation by voluntary agencies may be helpful.

CHAPTER 15 RESEARCH AND MENTAL HEALTH LAW

There is a general dearth of good research on, or audit of, mental health legislation in Scotland and elsewhere in terms of both outcomes and process. Some suggestions are made as to why this might be the case, which includes methodological difficulties, including problems of consent, the lack of a national data base geared towards research or audit, funding issues, publication issues and the impact of the research assessment exercise in universities.
CHAPTER ONE: THE LITERATURE REVIEW

REVIEW METHODOLOGY

Aims
1.1 Identify and report on the findings of literature relevant to the proposed reform of the Mental Health (Scotland) Act 1984

Criteria for inclusion
1.2 All reports, theses, conference papers and journal articles that contained empirical data or dedicated discussion of issues of relevance to mental health legislation UK and international and published from 1984 onwards. Over 1000 references were identified from which this selective review is drawn.

Search strategy
1.3 The keyword searching of online databases included Medline, Psychlit, Embase, BIDS and Current Legal Information (CLI) using the terms ‘Mental Health (Scotland) Act’ ‘Mental Health Act’, ‘mental health legislation’, ‘mental health law’ and, in the case of CLI, ‘mental health.’ Very little of relevance to this revue and not available through other database searches and alternative strategies was found on CLI despite a high number of ‘hits’.
1.4 The libraries of the Douglas Inch Centre and Gartnavel Royal Hospital were used to source some articles where journals were not held by Glasgow University Library. The university’s inter-library loan service was used almost exclusively for non-UK references.
1.5 Hand searching of some journals was undertaken from 1984 onwards especially when the publication was likely to provide relevant information but was not included on the databases. Journals hand-searched included: Psychiatric Bulletin; Journal of Forensic Psychiatry; Medicine Science and the Law; Law and Human Behaviour and Social Work Today.
1.6 First-level cross-reference searching was engaged in for articles that were particularly relevant and whose references had not been picked up via the keyword electronic search. This also provided the impetus for further hand searching.
1.7 Heads of all the Scottish universities’ Faculties and Departments of Psychiatry, Law, Social Work and Social Policy were contacted requesting relevant contributions. No information that was not otherwise identified resulted from this.
1.8 The Mental Welfare Commission for Scotland and the Mental Health Act Commission in England provided all their reports (annual and biennial respectively) from 1984 to 1999 on request.

Data extraction and management
1.9 The dedicated application software ‘Reference Manager’ was used in conjunction with ‘Word’ to manage the references and to produce the citations in the body of the text.
Arrangement of the Literature Review

1.10 The chronological order of the chapters and first-level subheadings are arranged in response to those within the Millan Committee’s First Consultation Paper contents headings insofar as literature is available and of relevance (Committee under the Chairmanship of Bruce Millan, 1999). Summaries are given in the same order as the chapter headings. Cross-referencing has been given throughout the review where an adequate summary of the information referred to in another section would be over-burdensome within the body of the text. For example this may appear in the text as ‘see paragraph [number]’ or ‘see from paragraph [number]’ depending on whether one or more paragraphs are referred to respectively.

MENTAL WELFARE COMMISSION DATA

1.11 Using the data presented in the annual reports presents a number of problems. The information collected and held by the MWC is not collected, or held, as a research database. Nor are the annual reports research reports. This is not a criticism, as they are not intended as such. It does mean, however, that data is not always presented in the same way or may be missing for some years. It does, however, allow us to indicate trends.

1.12 Although the MWC performs a monitoring role the information collected and reported in case notes, following visits for example, is not standard, either in content or recording. Our previous research on use of extended leave of absence, for example, was only able to give indications (of minimum use) of services by patients since this is not collected or recorded in a standard way, but depends on the concerns of the person making the visit (Atkinson et al. 1998). This is unfortunate since MWC records could form an important, and potentially easily accessible, source of information to monitor the impact of the use of the law on patients in Scotland.
CHAPTER TWO: OVERARCHING PRINCIPLES

2.1 The legal justifications for the civil commitment or detention of people with a mental disorder are the protection of the public (or police power) and public responsibility (or parens patriae). Achieving a balance between these two principles is a goal of mental health legislation. Typifying the first is the image of the ‘violent madman’ attacking a stranger at random, creating fear and a demand for protection. Typifying the second is the image of the ‘mentally ill down-and-out’ wandering the streets, creating a sense of guilt and outrage and a demand for something to be done. These are the two main media images of people with mental illness although the media focuses on the former (Philo, 1996). It is not, however, the whole picture, either of people with mental disorder or of the public’s attitudes, which seem to be developing a greater tolerance and understanding.

2.2 Underpinning mental health legislation is the belief that some people are prevented by their mental condition from acting rationally and/or autonomously and, indeed, because of this they are not responsible. A consequence of this is that other people must act on their behalf. These philosophical underpinnings do not appear in civil mental health legislation and only find expression in the question of criminal insanity. An argument can be made that there is no difference between mental and physical illnesses or that there should not be (Matthews, 1999). Those taking this position would argue that there is no need for specific mental health legalisation. This can be seen as one of the innovative principles in the 1978 legislation in Italy (Sarteschi et al. 1985). Leaving this aside this position this section will consider how differences in approach to the fundamental assumptions and different considerations given to police power and parens patriae translate into different specific details of law.

2.3 Different legal traditions, political and social movements, and researching and delivery of health care effect the way legislation has developed in different countries which have adapted the same principles to suit their own circumstances. Political and social factors which form a backdrop to reform of mental health legislation include civil rights, consumerism, resource constraints, professional and lay beliefs about the nature of mental illness and availability of treatments (Appelbaum, 1997). Legal traditions include, for example, the Bill of Rights in the United States of America, which enables people to claim distinct rights under the Constitution and to take their challenges to court. This was seen in the civil rights revolution of the 1950s and 1960s, which, by the 1960s included people with mental illness. Larry Gostin, an American civil rights lawyer introduced the civil rights approach into Britain, in the 1970s although the American emphasis on due process of law sat less easily in the reforming atmosphere here. The impact in Britain of the adoption of the European Convention on Human Rights has yet to be fully tested in relation to the rights of people with mental illness. This is further discussed in the chapter on Patient’s Rights from paragraph 11.1.

2.4 These forces came together over a 15 year period, in the USA, to overthrow the previous standard for commitment, which was solely that the person was “in need of treatment” and to limit involuntary commitment to those who were likely to be a danger to themselves or others. It is also possible to commit someone who is “gravely disabled” and thus unable to take care of their basic needs. In the US the focus on due process, together with the dangerousness criteria, have led to “criminal-style procedures” (Appelbaum, 1997) or the “criminalisation of civil commitment” (Stone, 1985). This has lead to a position where:

“instead of providing a clear basis for commitment, the concept of dangerousness is now sometimes seen as the villain, rather than the
showpiece, of civil libertarianism and progressive reforms in the law and psychiatry” (Soothill et al. 1990).

2.5 Other countries which followed the US by adopting a dangerousness-based criteria include Austria; Belgium; Canada (Ontario); Germany; Israel; the Netherlands; Northern Ireland; Russia and Taiwan. It also forms the basis of the law, with some amendments, in other places, such as New South Wales and the Capital Territory in Australia (Appelbaum, 1997).

2.6 Set against the dangerousness criteria is the English model (Mental Health Act 1983) which requires the person to have a mental disorder “of a nature or degree” that makes treatment in hospital appropriate. It must also be necessary for the person’s health and safety, or for the safety or protection of others. Some would argue that the “implicit notion of dangerousness remains pervasive” within this framework (Soothill et al. 1990). The other major difference, of course, is the role of the courts or ‘due process’. Detention is not the result of an adversarial judicial process but through application by a specially trained social worker or a relative, supported by medical recommendations, to hospital managers.

2.7 Appelbaum suggests that the British model is followed internationally more often than what he describes as “the more rigorous American model” (Appelbaum, 1997). Countries broadly adopting a British approach include most of Australia (Northern Territory, South Australia, Queensland, Victoria), Denmark, Finland, France, Greece, Italy, Ireland, Japan, Norway, Sweden and Switzerland.

DANGEROUSNESS

2.8 The United States has been at the forefront of using dangerousness as criteria for commitment and as a consequence the study of the impact of using this as criteria. It is also there that most of the studies considering the predication of dangerousness have been carried out. Concern about dangerousness can be argued to be implicit in British mental health law (Soothill et al. 1990). During the reforming period of the 1970s, MIND argued that dangerousness should be the only criterion for detention:

“Only grave and genuinely probable future harm to others should form the basis of compulsory admission, and this prediction should be based on recent overt acts” (Soothill et al. 1990).

2.9 The uncertainty in predicting dangerousness (see below) had lead to some questioning its suitability as a standard for detention. Others, however, have argued that “predications of dangerousness are objectionable in principle” (Schopp and Quattrrocchi, 1995). The reason given is that:

“Experts who predict dangerousness for the purpose of civil commitment conflate empirical and normative judgements and they fuse the roles of witness and decision maker” (Schopp and Quattrrocchi, 1995).

2.10 Although it is generally accepted that the public should be protected from those with a mental disorder who are a threat to others, the question of why different standards /conditions should apply to the danger from a mentally disordered individual and the dangerous ‘normal’ individual is rarely debated.
Problems in defining dangerousness

2.11 Inherent in the problem of defining dangerousness is the difficulty of using the same word to describe harm to others and harm to self. This includes whether it is reasonable to describe ‘self-neglect’ as ‘dangerous’ as well as concerns about whether different levels of dangerousness should apply to the risk of the individual harming him/herself or others. Dangerousness is also usually situation-specific and may require complicated formulae to determine risk, for example when the likelihood of danger is high but in a rare situation. Danger to property is not included in the law in Britain yet not infrequently is used as part of the criteria for detention.

2.12 Dangerousness as a criteria for detention can be interpreted more or less widely both in the detail of the law and in its interpretation in the courts. Thus in New South Wales, Australia, danger of serious physical harm to others includes nuisance or harassment of a nature which could lead to violence (Durham, 1988b; Appelbaum, 1997). Protection from danger to self can include serious financial irresponsibility and sexual promiscuity for individuals with bipolar disorder but not others (Singh, 1996).

2.13 In Israel protection of others can include the commitment of someone with a mental illness who causes severe mental suffering to others (Appelbaum, 1997).

2.14 Japan makes an interesting distinction in that if the authorities initiate commitment then dangerousness is a necessary condition, whereas if the family is responsible for initiating the commitment then it only needs for the person to be mentally disordered and in need of hospitalisation. This reflects both the Japanese tradition of the role of the family in decision making for the individual (Appelbaum, 1997) but also the responsibility placed on the family to care for their own. This is discussed under the hogosha system from paragraph 5.18.

2.15 The Republic of Ireland’s Green Paper on Mental Health suggested that “serious likelihood of immediate harm” might be a more appropriate criterion than the more problematical dangerousness, a wording supported by the Irish Division of the Royal College of Psychiatrists (Brophy, 1994).

Assessment of risk of dangerousness

2.16 There is not the time or space here to debate the complex and sometimes controversial area of risk assessment. Assessing dangerousness, whether as a risk of suicide or violence to others is necessarily imprecise and there is a potential clash of ideologies. Psychiatrists are more likely to work on the basis of high risk whereas lawyers are more likely to proceed on certainties. Although a distinction is made between the actuarial predication and the clinical judgement of dangerousness Roth and Bluglass suggest that conceptually there is little difference, since clinical judgement has to be based on past experience of a sufficient number of cases to allow for generalisation (Roth and Bluglass, 1985). They suggest that even an experienced psychiatrist presented with ‘a person truly unique in respect of features relevant to dangerousness” would be able to do little more than “contemplate him in ineffable wonder and perplexity”.

2.17 Although actuarial prediction may be as useful as prediction based on clinical characteristics there are questions around the legal and moral justification of detaining an individual because they belong to a group based on statistical categories (Schopp and Quattrocchi, 1995). Even if people with mental illness are more dangerous as a group than the general population then using this as a predictive measure depends on whether this means that each person in that category is more dangerous. Then simply having a mental illness would be
sufficient for commitment. However, if some people with a mental illness are no more
dangerous than the general public then other criteria are necessary.

2.18 Questions to be considered in the application of risk assessment include: What
constitutes a high risk?; Is a lower criterion of risk more appropriate when protecting the
public than the individual?; What is a reasonable level of risk for the public to tolerate?; Is the
public’s attitude to the risk they should tolerate socially and morally defensible?; Which is the
more serious travesty of justice - false positives or false negatives?; Should there be a
difference if someone is known to be of high risk if they have a diagnosis of mental illness, a
personality disorder or has no disorder at all (are ‘normal’)?; Does this difference come down
to a question of whether the person is susceptible to treatment?

2.19 Unfortunately many of these questions are not amenable to empirical research nor is
there good evidence indicating clearly current public opinion. The role of mediating factors to
reduce risk is also less well documented than would be useful.

2.20 These problems lead some to argue that mental health professionals acting as expert
witnesses should never testify to predict dangerousness but that they can testify to explain risk
(Schopp and Quattrocchi, 1995). This is in part because statutory dangerousness, for the
purpose of civil commitment, is a current attribute/state of the individual and not a future state
to be predicated. Also, dangerousness as a legal concept includes a ‘normative component’
which takes it beyond the range of clinical expertise (Schopp and Quattrocchi, 1995). However a court, as a normative judicial decision, can determine dangerousness as a current
property of the individual.

2.21 Different statutes word the ‘dangerous’ or ‘harm’ condition in various ways which can
lead to situations where it would be possible to argue that the statute requires the person to
represent a risk of harm (which might include being psychotic) but does not require a
prediction that the person will perform harmful acts in the future (Schopp and Quattrocchi,
1995)

The use of dangerousness criteria

2.22 The impact of the legal reforms in tightening commitment criteria in respect of
dangerousness in the States has been limited (Appelbaum, 1994). In many States rates of
commitment had been declining before the changes and continued to decline in line with these,
but no change was indicated in respect to the new laws. This decrease reflected a reduction in
public sector beds and state facilities generally and a move towards community care. Where
rates did decrease this tended to reflect a short (often one year) follow-up period. Studies
beyond this date suggested that commitment levels returned to, or exceeded previous levels
(Bagby and Atkinson, 1988). Neither did the changes in the law seem to be reflected in
changes in the detained population, who were no more likely to meet the new criteria after the
changes in the law than before (Appelbaum, 1997).

2.23 Shortly after the introduction of the 1983 Act Dean and Webster, in Manchester,
compared 90 consecutively detained patients with a matched patient who was the next to be
admitted to the same ward (Dean and Webster, 1991). They were matched for age (in bands
under 35, 35-65 and over 65), diagnosis at that admission and consultant psychiatrist by whom
they were admitted. No differences were found between groups when compared by sex,
ethnic group, educational status, accommodation, living group, employment status or social
class. Numbers were very small for ethnic group comparison. Detained patients were
significantly more likely to have had a criminal conviction involving violence. They were also
significantly more often involved in violent self-harm incidents prior to admission. Nevertheless, 62% of detained patients did not have a history of identified violence or self-harm prior to admission. The detained patient showed significantly greater severity of illness and disturbed behaviour on admission. They were also less likely to think they were ill, in need of treatment or should be in hospital. Their length of stay in hospital was significantly longer (median 43 days compared to 27 days for voluntary patients). Detained patients were significantly more likely to be held in seclusion or held on a secure ward for part of their admission although this applies to small numbers.

2.24 Although these findings might be expected it is worth noting that some voluntary patients resisted admission, refused medication and absconded. It is not clear why some were detained and the others not, although the difference between the groups in relation to past dangerousness and insight might play a part.

2.25 A recent study in Oklahoma considered the issue that the:

“reforms in civil commitment standards and procedures have not translated into reforms in practice” (Pokorny and Shull, 1999).

The most important factors in decisions whether to discharge emergency detained patients (people detained by the police) or commit such patients (following a court hearing) for 28 days of treatment was “influenced primarily by clinically relevant indicators of patients’ overall degree of impairment”.

2.26 Discriminating between involuntary and voluntary patients’ dangerousness as well as disability was significant. For example, involuntary patients were more likely to have made a suicide attempt whereas voluntary patients were more likely to exhibit suicidal intent. Involuntary patients were likely to have a more severe overall impairment and to have significant psychotic symptoms than voluntary patients. However, “failure to perform activities of daily living”, which was the variable closest to the “grave disability” standard for commitment, was more common as a reason for admission in voluntary than involuntary patients. The most common dimensions of dangerousness precipitating involuntary admission were “hostile” (which included threatening behaviour and assaults) (39%) and suicide attempts (21%).

2.27 In Britain Soothill et al looked at how and whether dangerousness was assessed in a series of 53 patients admitted compulsorily to one hospital covering the catchment areas of Ladywood and South Soho in Birmingham (Soothill et al. 1990). Danger, which could be to self or others, was divided into three categories: nil or no evidence; mild or minor danger and significant or serious danger. Mild or minor danger included neglect of self-hygiene, not eating or sleeping, and also disturbances to others such as making loud noises. Significant or serious danger included assault with a weapon and self-harm. Level of dangerousness at admission was assessed from case notes, with all the methodological problems inherent in that, not least the potential lack of relevant information being recorded.

2.28 The results were 49% of case notes recorded significant danger and 51% of case notes had no record of significant danger. Separate figures for the mild/minor category are not given. Within the 49%, significant danger to others accounted for 28%, to self 15% and to both self and others 6%. They looked for destruction of property and found 10 cases, of whom 4 did not also have significant danger to self or others. They conclude that about 43% of this detained cohort “cannot be regarded as having committed significant acts of danger to self, others or property at the time of admission” (Soothill et al. 1990).
2.29 Other features of the population were that 89% had a previous psychiatric history and 40% has a previous history of significant dangerousness to self or others. Of these, at the time of the current compulsory admission half were not recorded as having “displayed significantly dangerous acts to self or others.”

2.30 In terms of projected outcome regarding dangerousness, of the 26 cases where significant danger was recorded at admission only 4 were of concern regarding danger in the future. Of the 10 who had a history of danger but were not recorded as having a significant dangerous incident at admission 6 were of concern regarding future dangerousness. Of the remaining 17 who had neither a history of dangerousness nor were recorded as such at admission only one was considered to be a future risk.

2.31 Soothill et al compared their study with the work of Bean from the 1970s. In so doing they conclude that:

“There has been little, if any, shift in the way that psychiatrists use the concept of dangerousness in assessing persons for compulsory admissions [and that, presumably in line with the 1983 Mental Health Act] dangerousness is not the primary issue of concern in terms of compulsory admission” (Soothill et al. 1990).

2.32 Concern has been expressed that some groups are stereotypically seen as likely to be more dangerous than others. In the Soothill et al study the catchment area had a high proportion of both people from ethnic minorities and people living alone (including caring alone for minors). Comparing those who were recorded as displaying significant danger at the time of admission Soothill et al found no difference in terms of age, sex, ethnic origin, accommodation, drug use, previous psychiatric treatment, source of admission, diagnosis, physical illness or mental state at discharge. They conclude that “among this sample at least, prejudicial stereotyping is not taking place”(Soothill et al. 1990).

2.33 A study in Oklahoma, USA also suggested that ‘personal resources’ and demographic characteristics added little to discrimination between voluntary and involuntary admitted patients (Pokorny and Shull, 1999). Patients who had been detained as an emergency by police were more likely to be committed by the courts if they had better education and were veterans. The latter probably related to eligibility both for veterans’ benefits and treatment and follow-up at a Veterans Administration facility.

‘INTUITIVE CRITERIA’ OR COMMON-SENSE

2.34 Explaining the findings that in some American States the commitment rates dropped immediately after the narrowing criteria of new legislation but then rose to previous levels Appelbaum argues 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” (Appelbaum, 1997).

2.35 In the States this reflects the narrow dangerousness criterion which:

“violates the common-sense intuition of the majority of the population that severely ill people who could be helped by treatment should receive treatment, even if it must be provided against their will” (Appelbaum, 1997).
2.36 This has been noted in studies in the USA (Warren, 1982), in Norway (Hoyer, 1986) and in mental health review tribunals (MHRT) in England (Webster et al. 1987; Peay, 1990; Wood, 1993). Where appeals are upheld it is more likely to reflect the patients availability for discharge than whether or not they met commitment criteria.

2.37 The civil commitment process in the United States requires the detained patient to be allocated a lawyer “whose task is to be a zealous advocate for liberty” (Stone, 1985). It also requires proof, beyond reasonable doubt, to be presented that the person presents a danger. Appelbaum notes a series of studies in the USA and Australia which indicate that lawyers acting for patients often acted in what they believed to be the patient’s best interest which was continued treatment, rather than vigorously pursuing the patient’s appeal. Thus expected adversarial legal proceeding did not occur (Poythress, 1978; Warren 1982; Bottomley 1987). There is no evidence of whether this is still the case or how far this might apply to Britain, where legal appeals are less likely.

2.38 Zusman gave a personal account of the use the law

“my experience suggests that no matter how clear or detailed a law is, judges, police, attorneys and bureaucrats often ignore or have no knowledge of its fine points. These officials, especially judges who are often not accountable to anyone, routinely do what they think is best for the patient, or what the law intends without regard to what the law really says” (Zusman, 1985).

He supported this view by the example of Florida which until 1984 did not make provision for the commitment of people who were suicidal. Despite this, involuntary admissions showed the same pattern as States where it was allowed. Juries are also likely to make decisions based on what might be considered common sense or ‘rough justice’ in cases involving the insanity defence. This has happened in both Britain and the United States (Reznek, 1997). Both Appelbaum and Slovenko reviewing the literature show that psychiatrists are equally likely to bend the law in the interests of providing treatment (Slovenko, 1989; Appelbaum, 1997). Bagby and Atkinson, (1988) refer to this as “psychological reactance” by the professionals.

2.39 In almost all cases these legal and clinical outcomes are accomplished through the flexible use of inherently vague criteria such as ‘gravely disabled’ and ‘unable to care for self’. Slovenko also suggests that diagnosis may be employed to secure commitment (Slovenko, 1989). He gives the example of Michigan, which has a definition of mental illness close to psychosis but finds that 36% of a sample of 116 involuntary committed patients have a diagnosis of “adjustment disorder” as a “way to provide for commitment in cases of addiction”. He also indicated that the “vast majority” of people committed in Detroit use crack cocaine. Some work has suggested that psychiatrists may ‘talk up’ the risk of dangerousness where the psychiatric condition was rated highly, for purposes of detention (Soothill et al. 1990).

2.40 Indeed Chodoff argues that psychiatrists “succumb” to what he sees as prevailing fashion if they believe detention to be in their patient’s best interest and do not seek to act in these interests (Chodoff, 1976; McGarry and Chodoff, 1981). Perlin suggests that this notion that there is a “higher morality” to which mental health professionals (and, presumably the lawyers in such cases) “owe some sort of higher duty”, is both “empirically, an extraordinarily important one” and one that is “strangely under discussed” (Perlin, 1991). Research examining these questions is largely lacking, particularly in relation to Britain.

2.41 Similar solutions may arise in relation to people being detained as “mentally impaired” under MHA 1983 where “seriously irresponsible conduct” is interpreted widely to protect
patients vulnerable to abuse and neglect. Davison et al describe a number of “technically” irregular arrangements and actions to allow “common-sense decisions concerning the welfare of sufferers [of dementia] and their families” which are acceptable to all involved (Davison et al. 1993). This ranges from a bank manager allowing a relative access to a patient’s account or a solicitor stretching the interpretation of capability so that a relative may have formal power of attorney to a home help paying bills. The authors comment that:

“this pragmatic approach is seen as an aid to flexible and appropriate resolutions by some, and as a potential injustice by others” (Davison et al. 1993).

2.42 Appelbaum argues that these “widely held views” which influence the practice of law should be taken into account in framing law (Appelbaum, 1997). This is not only because they might reflect some inherent truth, but also because otherwise they will undermine the practice of law. He concludes that, “Compromise should be considered the goal, not the second-best outcome, of policy formulation in mental health law”.

LEGAL AND CLINICAL TENSIONS

2.43 The history of mental health legislation can be seen as a pendulum swinging between the interests of lawyers and the interests of psychiatrists (now, more broadly, mental health professionals). It can also be perceived as trying to balance these two sides in a bid to do what they believe to be in the patients’ best interests. As has already been noted, Britain and the United States currently have taken somewhat different approaches, with the American focus on due process of law and the British approach being more clinically inclined. This is not to say that there are no legal safeguards in the British system and it could be argued that the acceptance of the European Declaration of Human Rights will serve not only to strengthen further legal challenges but influence the practice of mental health law. Most people prefer the non-judicial approach although the major international review supporting this contention is now over 20 years old (Curran, 1978).

2.44 A number of differences between lawyers and clinicians will have an effect on their approach to mental health legislation. The lawyer’s need for certainty versus the psychiatrist’s reliance on best estimates has already been discussed in relation to dangerousness. Clinicians are more concerned with the needs (including care and treatment) of their patient than public safety. Campbell suggests that clinicians are concerned with the good of the individual and lawyers with the good of society, or the greatest number (Campbell, 1985). It is also perceived as an error on the part of doctors to assume that the law has but one meaning. As Slovenko points out, the written decision of a court is an opinion, which is open to interpretation and thus gives rise to other opinions (Slovenko, 1989). He quotes Abraham, a law professor, when he says, “Doctors say medicine is an art but they look upon the law as cookbook rules”.

2.45 Perlin argues that the tensions between legal and mental health systems can only be understood by considering the dissonances that affect both systems (Perlin, 1991). The law, he argues,

“Frequently condones pretextuality as a way of dealing with troubling or cognitively dissonant information, [while mental health professionals] encourage a self-referential concept of morality as a way of subverting legal doctrines with which they disagree” (Perlin, 1991).
2.46 Perlin argues that judges (and lawyers) frequently mistrust psychiatry and social science research while at the same time requiring psychiatrists to act as expert witnesses to testify as to an individual’s future dangerousness.

DUE PROCESS

2.47 The greatest advocate of due process in Britain has been Larry Gostin who worked for the National Association for Mental Health (MIND). He describes due process as:

“a principle founded upon the general right to a determination by a court of law concerning the need for deprivation of liberty or self-determination” (Gostin, 1985).

2.48 This approach is upheld in the European Convention of Human Rights, the International Covenant of Civil and Political Rights, and national constitutions such as that of the United States of America and the Canadian Charter.

2.49 Gostin argues that judicial approval of commitment and the intervention of the courts are not to arrive at the “right or correct” decision but are about “ensuring fairness”. This is an important distinction since, as he points out, there “is no reason to presume that courts make a better decision than doctors”. He assumes, however, that a court review will give the individual access to:

“an independent decision maker who will consider all the evidence which the individual can bring to bear to refute the case for the deprivation of autonomy” (Gostin, 1985).

This requires us to raise a number of issues. The first of these might be whether the person with mental illness is autonomous, at that particular point in time. A second might be to question the independence of the judge (sheriff, magistrate or whoever) if, by independent is implied or inferred ‘value neutral’. As indicated earlier lawyers may be as likely to bend the law to suit what they perceive as ‘best (for the patient)’ as psychiatrists do (Gostin, 1985).

2.50 The judicial aspects which Gostin wanted to see in place were:

- a hearing without secrecy with publicly funded representation and expert advice
- knowledge of all the information being available to the court
- to be able to comment on and question witnesses
- to be given reasons for the decision that the court reaches.

He was not advocating due process procedures such as jury trial, criminal standards of proof, the right to remain silent or the demonstration of past criminal behaviour. It is worth noting the importance of knowledge of past dangerousness in the prediction of risk for future dangerousness in relation to the last point.

2.51 Gostin also asserts that an informal atmosphere “as with a multidisciplinary tribunal in England and Wales can avoid many of the objections to a judicial review”. An informal atmosphere is surely to be welcomed but it does not necessarily avoid damaging the doctor-patient relationship through what may still be an adversarial process.

2.52 It has also be argued that judicial review prevents access to treatment (except in emergency cases). Gostin argues that this is “ill-founded” since, until the review, whether the person requires treatment is still to be “impartially established”. Part of the issue here will concern whether treatment can be given pending a review or appeal. He cites a case in
Canada where a man was hospitalised without treatment for two years because of lengthy legal proceedings before treatment was eventually started (Gostin, 1985).

**TREATABILITY**

2.53 Treatability has been put forward as a possible underlying principle for mental health legislation; that it is not reasonable to detain a person unless something can be done to alleviate their condition. This is often set against the issue of dangerousness, particularly public safety. In this section treatability will be considered separate to these other issues.

2.54 Treatability raises a number of general issues including; what is ‘treatment’ or what counts as ‘treatability’? Should there be time limits? How does co-operation interact with treatability? This latter point is of concern in relation to the right to refuse treatment. It could be argued that it is unreasonable to define someone as untreatable if they refuse treatment since then an individual only has to refuse treatment to become ineligible for detention, if this is the criterion. There is, however, a distinction to be made between refusal of medication, or other physical treatments (such as ECT) and refusal which is manifest by non-co-operation with psychotherapy or group therapy. It is possible to enforce a physical treatment, such as medication, against a person’s wishes and still expect a positive therapeutic outcome where it is not possible to force someone to engage co-operatively with psychotherapy.

2.55 At present treatability as a condition of detention only applies to people with a psychopathic disorder rather than a mental illness in Britain. Many of the issues have been rehearsed in the case of *R. v. Cannons Park Mental Health Review Tribunal, ex parte A* (1995) QB60 CA and discussed by Glover. In this case a woman with a diagnosis of a psychopathic disorder appealed to a MHRT for discharge on the grounds that her condition was not likely to respond to hospital treatment (Glover, 1996). The psychiatrists involved had suggested that the only therapy likely to be effective was group therapy and the patient refused to co-operate with this. Part of the case was based on the different wording in two parts of the Act (section 3 and section 72 (1)(b)(i) in respect to treatability.

2.56 The Court of Appeal set out six principles for treatability:

> “The tribunal would be under a duty to discharge the patient if the patient’s detention in hospital was simply an ‘attempt to coerce the patient into participating in group therapy’

> The ‘treatability’ test will be satisfied if treatment in hospital is likely to prevent a deterioration of the patient’s condition

> Immediate alleviation is not required to satisfy the ‘treatability’ test

> The ‘treatability’ test can be met even if deterioration of the patient’s condition occurs before it is improved

> Section 145 of the 1983 Act allows for medical treatment in hospital to cover nursing, care, habilitation and rehabilitation

> If nursing care could lead to the patient’s condition improving enough to enable her to get an insight into her own condition and, thus, to co-operate in effective treatment, the treatability test is satisfied.” (Glover, 1996)

2.57 There is clearly a potential problem in the last condition if, for example, ‘insight’ is never likely to be achieved, that the reason for non-co-operation is not based on lack of insight and thus hospitalisation is no more than coercion to accept treatment.
2.58 Force feeding has also been declared legal and falling within the meaning of the 1983 Act for a person with a psychopathic/borderline personality disorder and post-traumatic stress disorder who had symptoms of depression and self-harm which included stopping eating (Gunn, 1995).

**Treatability and diagnosis**

2.59 There are inherent problems if treatability is limited to one group of disorders under the legislation. This might result in psychiatrists changing diagnosis or being put under pressure to use a particular diagnosis either to keep someone in hospital or to prevent someone being hospitalised. This is a current problem in the law. It is not known how much this happens, but there are examples. One is in the previously mentioned case R. v. Cannons Park MHRT. After her original detention under section 3 of the Mental Health Act 1983 the patient was rediagnosed as having a psychopathic disorder. Having been discharged by the MHRT following the order of the Divisional Court she was subsequently readmitted under section 3 again with a diagnosis of mental illness.

2.60 Although there can be genuine changes in diagnosis as more is discovered about a patient’s condition the potential for a particular diagnosis to be made to meet, not meet or avoid treatability criteria cannot be overlooked. As discussed elsewhere, changes to the law have been made in the past with political aims, such as reducing the number of patients liable to detention for resource reasons.

**RECIROCITY**

2.61 Although consideration is not given to the provision and adequacy of resources in the review of the Mental Health Act there are two issues of resources which impact on legislation. One is the concern that reduction of acute beds has put pressure on services and has lead to more detentions. This has not been researched as such. More detained patients leads to increases in staffing of acute beds. This has led to situations where, although resources are increasing they are “almost entirely reserved for those who do not want them” (Eastman, 1994). Whilst this might be something of an overstatement it does raise the question of what services are and should be available to involuntary patients.

2.62 Eastman cites the principle of reciprocity as one of the suggested guiding principles arising from a conference to discuss possible changes to the Mental Health Act (Eastman, 1994). He defines the principle of reciprocity as insisting “that restriction or removal of civil liberties for the purpose of care must be matched by adequate quality of services”. He further asserts that, “even protection of the public cannot justify detention for treatment without adequate resources”.

2.63 Although cited in a number of articles there is little discussion about reciprocity and possible implications for detention. Some of the arguments are rehearsed in the section on right to treatment (from paragraph 11.5), including the decision by some US courts to discharge patients where services were not available. There needs to be clarity, not just about what constitutes adequate services, and who makes this decision, but the relationship between services and treatment.

2.64 The right to refuse treatment is not discussed in the context of reciprocity. Of particular importance is who decides what is adequate or appropriate. For example, the cases where someone with a diagnosis of personality disorder argues for discharge on the basis that
they are not being treated having refused psychotherapy. Concerns have been raised on a number of occasions about rationing of the newer, and more expensive, anti-psychotic drugs. If patients are detained will such drugs be offered as a matter of course (when the clinician deems them appropriate, regardless of budget costs) or would the patient have a right to demand these drugs? Concern is expressed that detention could become a route to such drugs, or indeed services.

2.65 This concern has been expressed in relation to both supervised discharge and community care orders (CCOs). Our current research on community care orders suggests that this does not happen as much as is possibly feared, and that many psychiatrists comment that the patient might benefit from “more” services, but they are limited by what the patient will agree to co-operate with (Atkinson et al. 2000).

2.66 Does “adequate quality of services” in the definition of reciprocity imply nationally agreed standards or provision of certain services or does it allow for geographical differences? Could this lead to, and would it be appropriate for, different parts of the country to have different patterns of detention based on services available? In theory this could lead to patients moving to an area with poor services to escape detention and thus putting more pressure on an already inadequate service. This seems unlikely to happen. Despite a few cases noted in countries where different states, provinces and territories have different laws this does not seem to be an issue.

2.67 During the 9 years when the restrictions on leave of absence (LOA) in England & Wales and Scotland were very different there was no exodus of Scots south of the border to escape being on extended leave of absence for more than six months (Atkinson et al. 1997). Although we might expect patients to be largely unaware of this aspect of the law the practical problems of moving and obtaining services in a new area where one has no claim would seem to make this scenario unlikely.

2.68 The study of LOA across Scotland gives no clear message about what influences use of detention by geographical area, and there is a suggestion that the individual psychiatrist may be one of the more important variables (Atkinson et al. 1997). There is no research on this, but it would echo the observation that individual judges account for the variation in sentencing in criminal courts.

2.69 The lack of knowledge of both professionals and patients about the law and patients rights must also be seen as an aspect as reciprocity. Adequate services do not make up for unlawful detention (or conditions under CCOs). This raises questions about advocacy for patients and who, if anyone, has a duty to inform patients if a problem with their detention is uncovered.
CHAPTER THREE: DEFINITIONS OF MENTAL ILLNESS

ELIGIBILITY FOR DETENTION

3.1 Who is to be eligible for detention under mental health legislation is set out in a variety of ways. Some Acts seek to define “mental illness” whereas others leave the concept open or, indeed, end up with a definition that is circular. It must be remembered that although mental illness (or learning disability) may be necessary conditions for detention, they are never sufficient conditions. Thus a mentally ill person, in the terms of various Acts, will be someone with a mental illness (however defined) who also fulfils whatever other conditions are laid out, such as danger to self or others.

3.2 Definitions can be laid down more or less broadly in legislation and may be influenced by the desire to include as many or as few patients as currently socially and politically fashionable, or for whom psychiatrists are willing to take responsibility, as well as more specific exclusion criteria (see below). Thus Slovenko argues the definition of ‘mental illness’ from the Michigan Mental Health Code (1974) as a:

“substantial disorder of mood or thought which significantly impairs judgement, behaviour, capacity to recognise reality or ability to cope with the ordinary demands of life” (Slovenko, 1989).

3.3 This was aimed at limiting admission to hospital by essentially defining psychosis. This is further discussed in the section on intuitive criteria from paragraph 2.34.

3.4 Broad definitions or lack of specificity may be seen as an ‘asset’ when it means that the court has to consider cases individually, taking in different circumstances and forms of impairment. A precise or narrow definition could limit the courts’ ability to deal with novel circumstances. It does mean, however, that the interpretation of what is mental illness involves legal issues beyond the scope of clinical experience(Schopp and Quattrocchi, 1995). Broad definitions, however, can be seen as contributing, at least in part, to the abuse of psychiatric detention in both the USA and the Soviet Union in the recent past(Durham, 1988b).

3.5 Another consequence of a broad definition, Durham argues, is

“an erosion of the sense of individual moral responsibility, as anti-social and other forms of reckless behaviour, and attributes towards them and their management, become increasingly medicalised” (Durham, 1988b).

3.6 The Mental Health Act of 1990 in New South Wales, Australia lays down a fairly detailed definition(Singh, 1996). Mental illness is defined as a condition that seriously impairs the mental functioning of a person. This impairment can be either temporary or permanent and is characterised by the presence in the person of one or more symptoms. These are detailed in a list of delusions, hallucinations, and serious disorder of thought form, disturbance of mood or sustained and repeated behaviour that indicated that any of these symptoms might be present. As well as this there needs to be reasonable grounds for believing that the care, treatment or control of the person is necessary either for their or another’s protection from serious physical harm, which can include harassment.

3.7 A person may also come under the powers of the Act if they have a severe disturbance of mood or sustained and repeated irrational behaviour that indicated that there is an
underlying severe mood disturbance. Additionally and, as a result of that, there are reasonable grounds for believing that care, treatment or control of the person is necessary to protect the person from serious financial harm or serious damage to their reputation (this includes sexually promiscuous behaviour). Damage to important personal relationships is also a valid consideration. This latter category came about through lobbying by the Manic-Depressive Self Help Group (Singh, 1996). This means that it is possible for a person to be prevented from ruining themselves financially if they have manic depression, but not if they have schizophrenia, which seems to be an odd anomaly (Durham 1988b; Appelbaum, 1997).

3.8 When legislators took the view that someone with a mental illness had the “right to go silently mad”, Singh notes, it was a source of frustration to both mental health professionals and friends and family “who have to put up with such sufferers” (Singh, 1996). This may be an unfortunate turn of phrase, since later Singh asserts that “citizens have the right to remain sane and physically healthy” yet nevertheless indicates how easy it is to lose sight of whose interests are best served by mental health legislation.

3.9 As well as the above the NSW Act created a new category, namely Mentally Disordered Person. This is defined as: A person (whether or not the person is suffering from mental illness) is a mentally disorder person if the person’s behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds, that temporary care, treatment or control of the person is necessary:

“for the person’s own protection from serious physical harm; or for the protection of others from serious physical harm” (Singh, 1996).

3.10 Explicitly excluded from these behaviours are preferences in politics, religion, sex or philosophy or engaging in immoral conduct, illegal conduct, or having a developmental disability of mind or consuming drugs or alcohol or engaging in antisocial behaviour. Such individuals can be detained for a maximum of 3 working days. The example Singh gives is of someone attempting suicide through a drug overdose following the break-up of a relationship. No mention is made of whether such a provision could be used to enforce a Caesarean section on an unwilling woman who was not excluded because of religious or philosophical beliefs (see above). It would be interesting to know if it has been used for such purposes given the problems of using the Mental Health Act for this purpose as demonstrated in England in recent years.

3.11 The Irish Division of the Royal College of Psychiatrists in the Republic of Ireland suggested that it would be appropriate to detain those with a diagnosis of personality disorder, although most of those with a psychopathic personality disorder should be excluded, which is the opposite of the English law.

EXCLUSION CRITERIA

3.12 Exclusion criteria are usually a list of conditions/attributes which solely, or in combination do not constitute a ‘mentally ill person’ or someone who could be detained under the Act. Typically they include illegal or immoral conduct, religious, philosophical or political beliefs or opinions, any particular sexual preference or orientation, promiscuity, and the use of alcohol or drugs. New South Wales legislation excludes the category of ‘developmental disability of mind’ (Durham, 1988b; Singh, 1996) Are such exclusions necessary?

3.13 Durham argues that such lists are redundant twice over (Durham, 1988b). Firstly, because no “educated person” would accept that such behaviours would make someone a
“mentally ill person” and secondly, because legislation already has a list of criteria which have to be satisfied, along with mental illness, before someone can be detained.

3.14 Such exclusions might be appropriate in legislation where detention for psychopathic behaviour/personality disorder is allowed, since these are often imprecisely defined categories. He suggests that to have such a list is not “innocuous”. If such behaviours are legislated for as being not mental illness in the “certifiable sense” then it raises questions about the status of other conditions or attributes not on the list, but which might be regarded by some as mental illness. Will there be demands for such people to be detained and treated? Whether a “common-sense” notion of mental illness makes such exclusions unnecessary is debatable.
CHAPTER FOUR: COMMUNITY DETENTION

4.1 There are a number of different types of community detention but they fall broadly into those that have powers to enforce treatment (usually medication), and those that do not. The former include the community treatment orders CTOs) of Australia, New Zealand and Israel and most provisions under the law of the United States of America (outpatient commitment, OPC). Leave of absence in Britain and other forms of extended leave could be argued to have functioned as de facto CTOs for a group of patients previously detained. Preventative commitment orders have also been mentioned, which are essentially CTOs for patients who have not previously been admitted (Bean and Mounser, 1994). This latter suggestion by the Royal College of Psychiatrists was specifically for people with a mental illness and not other types of mental disorder as defined in the 1983 Act.

4.2 The latter include community care orders CCOs) in Scotland, aftercare under supervision or the supervised discharge order in England and Wales, community counselling orders (CCOs) in New South Wales and some OPCs in the States. Also falling in this category would be the supervision registers set up in England, although not created by primary legislation.

4.3 This section will consider the issues surrounding treatment in the community and then look at the types of, and evidence for the two types of community detention.

4.4 For ease community detention which included a mandate to enforce treatment will be referred to as CTO, orders which do not allow enforced treatment will be referred to as CCOs. Leave of absence, extended leave and similar will be referred to as LOA. Supervised discharge will be used where appropriate.

COMMUNITY DETENTION ISSUES

4.5 If the principle that patients should be detained/treated in the environment of least restriction then, it has been argued, community detention provides for this because it allows treatment/management in the community rather than hospital (Bean and Mounser, 1994; Hambridge and Watt, 1995; Osuna and Cuena, 1995; McIvor, 1998; Power, 1999). It has also been argued that patients are likely to gain more in insight and to make more effective use of community services (McIvor, 1998). Although lack of insight is likely to contribute to patients’ refusing treatment, this can be spread more widely: “Some patients just refuse to consider that they are ill or need help” (Turner, 1994). The supervision register could be argued to target particularly needy patients for additional services, for example, assertive outreach (Abdul-Hamid and Cooney, 1997). Patients who are “challenging” or “extremely difficult to manage on a personal level” have been picked out as suitable for CTOs since such patients “lend a powerful negative image to the otherwise genuine benefits of community care” (Turner, 1994).

4.6 A further argument for community detention, particularly CTOs is that there is no difference in compulsorily treating someone in hospital and in the community. The logic, it is claimed, is “irrefutable” and that “compulsory treatment is a right to which individuals are entitled” (Turner, 1994).

4.7 Set against this are more wide ranging concerns that community detention or supervision is a fundamental infringement of a patient’s civil liberties, or rights (Caldicott, 1994; Burns and Goddard, 1995; McIvor, 1998). Supervision registers were not introduced
through primary legislation which makes concern over their impact on civil liberties particularly high (Caldicott, 1994; Holloway, 1994; Prins, 1995; Tyrer and Kennedy, 1995; Cohen and Eastman, 1996; Baker, 1997). There is a peculiar condition of supervision registers in England and Wales that in some circumstances a patient does not have to be told that they are on the register. There is no appeal against being put on the register, even when patients do know that they are on it.

COMMUNITY TREATMENT ORDERS

4.8 There are concerns that CTOs are an infringement of the principles enshrined in the United Nations Charter (McIvor, 1998) and Article 5.1 of the European Convention Human Rights (Hall et al. 1995; Milton, 1998). This is through their interference with patients’ civil liberties over a considerable period of time. It is thought that supervision registers were unique to England and Wales and that the civil rights climate in many countries would make them unworkable. It is noted that in some places psychiatric case registers have been curtailed (Holloway, 1994).

4.9 The assumption that controls can be transferred between hospital and community, as if the community is simply an extension of the hospital, causes some people disquiet. This is especially so in terms of consent (Bean and Mounser, 1994), the person living outside hospital being accorded greater freedom in their decisions, particularly whether to take the drugs they are prescribed. This is further discussed in the section on capacity and consent from paragraph 12.1.

4.10 Community Treatment Orders represent the greatest restriction on a patient’s freedom because of the use of enforced medication (McIvor, 1998). MIND has argued that anyone who is able to live in the community should be able to do so with freedom of choice as to whether they take medication. Concern has been expressed over the ethical dilemma of forcing patients to take medication which may have unpleasant or disabling side effects and which may be of limited benefit to them (Bean and Mounser, 1994).

4.11 There is also concern that community detention, particularly CTOs might be extended for years (McIvor, 1998). Other objections include that community detention is an easy option for controlling difficult patients, that it may be disproportionately used with patients from ethnic minorities (McIvor, 1998) and that it (and specifically CTOs) have a negative impact on therapeutic relationships (Caldicott, 1994; Holloway, 1994; Burns and Goddard, 1995; McIvor, 1998). There is also concern about the “net widening” aspects of community detention (Bean and Mounser, 1994). Thus, they may be intended for a small number of patients, but if they are found to be useful for them, (group x) then there is a likelihood that people will want to try them out in a wider group (group y) and so on. If community detention, especially CTOs, only follow on from other compulsory powers there is concern that these might increase to allow for the use of a CTO.

4.12 It has been argued that it is “more honest” to describe community detention, and CTOs in particular as “community control” (Bean and Mounser, 1994) and of mental health staff becoming “parole agents” (Wexler and Winick, 1998) and take on a policing role (Prins, 1995). It is an extension of the police powers of the state and there is need for careful monitoring of possible abuse (Swartz et al. 1995).

4.13 There have also been arguments that community detention puts staff more at risk (Wexler and Winick, 1998). Also, that there is a greater liability of outpatient providers who are mandated to accept responsibility for treating patients in the community but, at the same
time, may have limited treatment resources and limited capacity to enforce the terms of the CTO (Swartz et al. 1995). Concern has been expressed that victims of violence by patients may be more successful in bringing negligence claims against psychiatrists whether patients were, or were not on the register (Caldicott, 1994; Holloway, 1994; Baker, 1997). This would lead to the practice of more defensive psychiatry (Baker, 1997). Although responsibility usually resides with the RMO under supervision registers it was not clear how a keyworker responsible for the patient’s actions was to be identified.

4.14 Finally, workload increases with the introduction of community measures but usually with no increase in resources or personnel (Caldicott, 1994; Burns and Goddard, 1995; McIvor 1998).

4.15 There is concern that community dentition, but in particular the introduction of the supervision registers, is a response to a political agenda rather than because of their clinical merit. A “backlash” to community care has been described following a number of inquiries following homicide, which have been highlighted in the media to which the government had to respond. Glover, from the Department of Health made the point of their political significance in appeasing the media and the public in presentations to the Royal College of Psychiatrists conferences in the mid 1990s.

4.16 In a careful analysis of the introduction of supervision registers Baker argues that:

“it is difficult to resist the conclusion that the initiation of supervision registers was motivated ....by the need of the government to respond to its own political problems” (Baker, 1997).

4.17 Supervision registers are seen as, “buttressing the government’s image with the voters” and containing, “elements that are designed to deflect public attention from the activities of central government” with the effect that it is able “to shirk responsibility for shortcomings in its policies”.

4.18 Elsewhere it has been argued that supervision registers were a natural outcome of the New Right and the development of community care provision under Thatcherite principles (Atkinson, 1996).

4.19 Many of the issues over the use of community detention combine the practical with the ethical.

4.20 There are a number of questions to be asked about community detention but little evidence to answer them.

**Who are community treatment orders suitable for?**

4.21 Guidance is generally unclear. With no clear guidelines as to who is suitable it is difficult to assess whether CTOs are under or over used. It has been suggested that low use may reflect the complexity of the operation of the law(McIvor, 1998).

**How will discharge from community detention be determined?**

4.22 Whether discharge is through a formal procedure which includes an appeal process or whether it is more informal there is the question of whether the patient has to prove that they will not relapse. If this is the case then the odds are stacked against the patient since, it has been argued, it is easier to show that help is require than not and it is easier to show that someone should be kept on an order than discharged(Bean and Mounser, 1994).
Sanctions

4.23 Generally it is assumed that anyone who refuses medication while on a CTO would be readmitted to hospital, or, in a few cases, to some other contained environment. Using a psychiatric hospital as a sanction in this way suggests that it is not like other hospitals, which is in contrast to psychiatrists’ and others’ efforts to suggest that psychiatric illness and psychiatric hospitals are no different from other types of illness and hospitals. The psychiatric hospital in this scenario becomes an “institution of control” (Bean and Mounser, 1994).

4.24 What would be the trigger points for readmission? Two have been suggested: refusal of treatment and deterioration of the patient’s condition. These are not identical. Should a patient who refuses medication but who is still well be readmitted if, in other circumstances that person would not meet criteria for readmission? (Bean and Mounser, 1994). Community detention is presented as an alternative to hospital but it would seem the only suggestion for enforcing it is to admit the person.

Who should make an order for community treatment orders?

4.25 Both the Royal College of Psychiatrists and British Association of Social Workers have laid claim to being the lead initiator in CTOs (Bean and Mounser, 1994).

Community options other than detention

4.26 Community detention does not imply one model of treatment or service delivery. It may be that some improvements in service delivery may lessen the need for community detention. For example, assertive outreach, care management, care programme approach, and compliance therapy (McIvor, 1998).

Availability of community treatment orders

4.27 Various forms of community detention, have been available in the United States since the mid-1970s and by 1995 twenty six States and the District of Colombia explicitly allowed for enforced medication through OPC. Not only does the law differ between States but its use and application varies between counties within the same State (Swartz et al. 1995). Community Treatment Orders have been introduced into the various Australian States and Territories and are also available in Israel. They are not generally available in the EU (Power, 1999) although LOA can be seen to have some of the same properties.

4.28 The different laws in different States and Territories in both Australia and USA have led to some patients moving State to avoid conditions and it has been questioned whether this would happen in the EU if countries had different types of laws (Power, 1999). This might be more of an issue if the different parts of Britain had different laws, but an investigation of LOA over 12 months indicated that only one patient left Scotland for England and the reason for this move is unknown (Atkinson et al. 1999).

Community treatment orders in Australia

4.29 The length of the initial order is variable, but there is usually provision for indefinite renewal in some way. Western Australia, for example, allows for treatment in the community including enforced medication for up to 12 months with renewal. There were no additional resources made available (McIvor, 1998).
4.30 In New South Wales CTOs are for 3 months and community counselling orders, which do not allow for enforced medication, are made for 6 months. Both can be renewed indefinitely. Between 1991-1992 there were 480 CTOs used but only 50 CCOs. Despite the small numbers on CCOs there is an indication that patients responded positively to them and that the patient could move from a CTO to a CCO giving the patient greater responsibility and greater choice regarding medication (McIvor, 1998).

4.31 Clinical guidelines are variable. Western Australia and New South Wales do not have guidelines as to the type of patient CTO is aimed at, for example.

4.32 Models for community detention vary and this may effect its use. In Victoria, for example CTOs are driven by a clinical rather than judicial concerns and in 1994 use was estimated at 20 per 100,000. New South Wales has a judicial model and South Australia has a guardianship model and a use in 1996 of 43 per 100,000 (Power, 1999). Overall there is a suggestion that CTOs effect between 3%-5% of inpatients.

4.33 Writing from personal experience of CTOs in Victoria it is contended that:

“a CTO does not confer any advantage to the patient in comparison with a comprehensive community care” (Manchanda et al. 1989).

Rather the reverse is suggested, that CTOs can alienate patients from services. The widespread use of CTOs in Australia and New Zealand to date, they point out, has produced little evidence to support their continued use.

**Community treatment orders in the United States of America**

4.34 There are three main uses of CTOs in the US and Australia. They are used as a form of conditional release for patients who are involuntarily detained and as an alternative to hospital for patients who otherwise meet the criteria for detention in hospital. They are also used as an alternative for patients who do not meet the criteria for involuntary inpatient admission but who are “at risk of severe decompensation” (Swartz et al. 1995).

4.35 Sanctions are variable and rarely explicit. In North Carolina, for example, patients who are non-compliant can be brought to appointments by police but cannot be hospitalised without going through the full procedure of psychiatric examination and a legal hearing finding that the patient meets the criteria for commitment. Thus a patient who was refusing medication but currently well could not be readmitted until they had relapsed to meet the criteria for involuntary commitment (Swartz et al. 1995).

**SUPERVISION REGISTERS**

4.36 Supervision registers were introduced in 1994 in England and Wales. There is some evidence of use but no research on outcomes.

4.37 The definitions for including people on a supervision register are not the same as those in Section 1 of the Mental Health Act 1983 and have been described as being “too broad” (Caldicott, 1994). It has been argued that including people with personality disorder may take services away from people with a mental illness (Holloway, 1994). Patients who should be included on the register are those who are at risk of serious violence, suicide and serious self-neglect. It has been argued that registers would be unlikely to be used for people with dementia since if they needed to be on the register services would already be in place making it unnecessary (Glover, 1994).
4.38 Several surveys have estimated how much they could be used and how much they are being used. Since psychiatrists generally opposed the use of supervision registers, particularly since no additional resources were to be provided to run them it could be argued that they might overestimate the number of people they would put on them to inflate costs and indicate how impractical they are. Numbers on them might be low both because of the extra work in implementing them and the concerns of psychiatrists about their usefulness.

4.39 Five studies have estimated the number of people who might be put on a register. The Royal College of Psychiatrists took Nottingham as representative of England and Wales, estimating there would be over 2,000 people on the register or 0.3% of the population (Caldicott, 1994). Laugharne (1994) estimated that 16% of an inner-city locality team case load would be on the register while Pugh and Gardner estimated that 76% of current in-patients in an inner city area in London would be on the register (Pugh and Gardner, 1994). In Bow and Poplar (London) a community caseload of 209 patients for whom there were details estimated that 24 (11%) were at current risk and that 96 (47%) would be at risk if untreated.

4.40 A survey of all the medium secure units in England and Wales gave a 79% response rate (15/19) (Isherwood, 1996). Thirteen planned to register patients and one planned to register patients at risk of violence only.

4.41 A survey in South West Thames Region reports 13 registers covering 374 patients or 0.012% of the population (Cohen and Eastman, 1996). The use of categories varied between registers, some using the 3 categories exclusively and others combing the categories to give 7 options. Patients were placed on the register for violence alone (34% cases) or violence in combination with one or 2 other categories (49%): self neglect alone (22%) or in combination (42%) and suicide alone (20%), or in combination (37%). One area introduced an ‘other’ category that included arsonists and sexual offenders.

4.42 There was a wide range across providers of violence 16-60%, self-neglect 17-46% and suicide 11-46%. The ratio by population ranged from 0.005% - 0.024%. These figures indicate that there are varying thresholds across areas both for inclusion on the register and for each category of patient risk. This could not be accounted for by deprivation (using Jarman categories). Neither was there a correlation with the number of people on the register at risk of suicide and the number of suicides in the District Health Authority.

4.43 Lambeth, Southwark and Lewisham Health Commission (LSLHC) looked at the implementation of the care programme approach (CPA) and supervision registers and concluded that if both were fully implemented they would run a “psychosis only service” (McCarthy and Roy, 1995). They proposed to use their own criteria for entering people on a register: major mental illness; incomplete symptomatic response or documented history of relapse following non-compliance and significant risk of violence or dangerousness to others consequent on psychotic symptomatology. No figures are given for estimated use.

4.44 These surveys indicate that, whether too broad or not, there is idiosyncratic interpretation of who should be included on a register and that the risk of violence is the one used, or said to be used, most commonly. If supervision registers were introduced as a political strategy to convince the public that something was being done about potentially violent mentally ill patients then this is how they have been interpreted by psychiatrists and other providers using them. This emphasis on violence needs to be set against the long known evidence that suicide rates are higher in people with severe mental illness than are homicide rates or incidences of serious violence (Taylor and Gunn, 1999).
4.45 The concentration on violence may also come about because the impact arising from a false negative is seen by professionals as more severe than from the false negative predication of suicide or self-neglect. This will continue while there are public inquiries, reported in the press, into homicides but not suicides.

OUTCOMES OF COMMUNITY DETENTION

4.46 There is little research on outcomes of community detention and are a number of methodological problems in assessing outcome. These include no clear guidance on who they should be used for, a variety of different models of community detention, models of service delivery and community settings. Furthermore, few have control groups or even clear comparison groups. There is no adequate attempt to measure the perceived or real coerciveness of different forms of community detention and there is no assessment of patients’, carers’ and clinicians’ attitudes which is seen as particularly relevant to the last point (Silove et al. 1986; Sensky and Hughes, 1991; Sensky et al. 1991; McIvor 1998). Interventions are usually unspecified as to type, frequency, intensity of treatment/intervention and, in some cases, patients may have received no treatment.

4.47 To measure outcome it is necessary to be clear what community detention is supposed to do and for whom. Generally it is viewed as being for someone with a serious mental illness that is at risk of deterioration if they are non-compliant with medication. They might also be seen to have a use for people who are treatment resistant but who are at additional risk, such as neglect (Power, 1999). Outcome then relies on the service being able to commit to making special provision for at risk patients. Generally community detention has been introduced with no additional resources (McIvor, 1998; Power, 1999). There is concern that, where no additional services exist, services could be directed away from other groups of patients, or that community detention would be used as an access route to resources (see also the section on reciprocity from paragraph 2.61).

4.48 Their most effective aspect has been described as to “persuade the persuadable” but there is no evidence that this is better than other clinical means of persuasion, including compliance therapy and managed care (Power, 1999).

4.49 Swartz et al reviewed a number of studies published in the 1980s and early 1990s (Swartz et al. 1995). They are all American and it must be remembered that community services have developed both in range, scope and variety of services provided since then. There is selection bias in almost all studies or characteristics of patients are not given. For example in one study patients were selected because of employment and family support which were expected to increase the patients’ likelihood of success in treatment (Hiday and Smith, 1987). In most studies there appears to be a problem with failure to enforce the community order.

4.50 Follow-up periods are variable. Hiday and Goodman indicate that only 13% of patients received an involuntary hospitalisation in the 90-day commitment period (Hiday and Goodman, 1982). In a review community patients did better, but it was still only a minority of patients (Swartz et al. 1995). Studies have indicated that combinations of inpatient and community detention have led to fewer hospitalisations per patient and shorter stays. Moreover, patients made greater use of community mental health services (Swartz et al. 1995; Amering et al. 1999; Petrila, 1999; Sugarman, 1999). After the new legislation those not on OPC also made greater use of the community services and it is suggested that it is the
improved services which is likely to account for the improved outcomes rather than the OPC *per se*.

4.51 Decreasing hospital admission is not the only outcome that might be important in the use of community detention. The assumption is that improved compliance with medication will improve social, clinical and other outcomes. There is little evidence for this, with one study reporting improved compliance but no other changes (Swartz et al. 1995). This may be due, in part, to the selection bias of those included, which has tended to exclude those with the most severe and persistent mental illness. One 1986 study did not show any difference in readmission rates but it is probably due to the OPCs not being enforced (Swartz et al. 1995).

4.52 Generally speaking this early American research points to OPCs having a limited, positive impact on hospital readmission and length of stay, but it is not possible to be clear about who OPCs work for, nor how community detention influences these outcomes. This has led to the suggestion for the need for a testable conceptual framework “that is sufficiently complex to interpret how OPC operates in the real world” (Swanson et al. 1997). They suggest that changing compliance behaviour may produce an indirect effect on a wide variety of variables, all of which may, or may not, have an impact on outcome. For example, being on community detention may lead to the mobilisation and use of more community mental health and other resources and these effect the overall improvement. It might be suggested that if it is the impact of interaction with this wide variety of resources which is important, where they do not exit community detention might be expected to have limited outcomes.

4.53 Swartz and colleagues are currently investigating some of these issues in a controlled trial. An initial finding is that medication non-compliance along with alcohol and substance abuse is significantly associated with serious violent acts in the community (Swartz et al. 1998). This requires careful consideration of the relationship between severe mental illness and alcohol and substance abuse and what the patient is being detained for and treated for in the community. If, for example, the patient is only violent when drunk and keeping them on medication prevents them getting drunk, is it the mental illness or the drunkenness which is being targeted by the use of a CTO?

4.54 Some later work has been carried out in Australia, notably by Power who reported from his unpublished MD thesis in a way which means that it is not possible to comment on his methodology (Power, 1999). He suggested the best outcomes for CTOs were for patients who were “older” (in this case over 28 years), who were in the “mid-phase” of their illness, and who had significantly worse compliance with community treatment prior to the CTO. It is not easy from this report to understand exactly how comparisons were made but he mentioned a matched, randomised control group of patients not on CTO, although those on CTO had greater levels of pre-existing morbidity. No indication is given of numbers of patients.

4.55 Patients on CTOs improved relatively better than those not on CTOs, although the length of follow-up is not given. He reported rates of 81% overall improvement on outpatient treatment adherence and that 70-90% improved on hospital rates, violence and overall symptom change. He noted that a small number (4%) were “clearly repulsed” by CTOs and this included them moving out of the area of jurisdiction (the different States and Territories introduced laws at different times and have laws with different conditions for CTOs). These individuals tended to be younger (less than 28 years) and at an earlier stage of their illness.

**LEAVE OF ABSENCE**
4.56 Leave of absence (LOA) is available under Scottish legislation for patients under section 27 for those on section 18. Until the Mental Health (Patients in the Community) Act of 1995 LOA could be extended indefinitely. Since the 1995 Act LOA is available for 12 months only. In England and Wales LOA is available for patients under section 17 for patients on section 3. Since a legal challenge in 1986 LOA has only been available for 6 months. Extended leave is available in Jersey under guardianship orders which allow for enforced treatment. These measures can be seen as de facto CTOs.

Patients on extended leave of absence in Scotland

4.57 Atkinson et al conducted a retrospective study on extended leave of absence (ELOA) during the period 1998-94 (Atkinson et al. 1997). The Mental Welfare Commission (MWC) case-notes for patients who had been on LOA for a continuous period of six months or more were examined to determine patient characteristics, outcomes and the use of ELOA. This extended period of LOA was defined as ELOA.

4.58 Most of the patients (59%) on ELOA were in the age range 26-45. There were more males (62%) than females and most were single (93% of men and 73% of women). The majority occupied private accommodation of which 46% lived with relatives or friends and 37% lived alone. The remaining 16% lived in supported accommodation. The percentage that did not have offspring increased from 57% in 1988 to 71% in 1994. During this period 90 people had children who were minors of which 43% had retained custody (25% of men and 53% of women). Most had a diagnosis of schizophrenia (73%) with bipolar disorder accounting for 14% and 10% having a diagnosis of paranoid psychosis.

Patients’ use of services while on leave of absence

4.59 Data on the use of services for patients on ELOA was taken from MWC case-notes. This information was recorded as a result of Commission officers’ visits to all patients who had been on LOA for a continuous period of over 6 months. It was recorded at the officers discretion and whilst information on this would be noted if it was seen as important, it was not comprehensive and was not recorded in a standardised manner.

4.60 However, taken as a minimum, 75% were noted as having good family support (usually from their mother), 24% had no contact with a community psychiatric nurse or social worker and 67% had no contact with a day care service. Good support was recorded as positive support occurring at least as regularly as once a week and, in many cases, support from a relative was on a daily basis (Atkinson et al. 1999).

Leave of absence patients’ risk

4.61 Assessment of a patient’s risk either to themselves or others was also problematical in terms of the indeterminate level of under-reporting of incidents (Atkinson et al. 1999). Risk was identified through the documentation of a specific incident, and/or a medical practitioner’s explicit statement of the existence of risk. The 285 patients at risk of harm to themselves had a recorded incident of self-harm in only 52% of cases. There were a total of 161 incidents of self-harm of which 68% were recorded as suicide attempts while a further 6% were threatened suicide. Other recorded risks to self were, 7% self-mutilation, 10% self-neglect, 7% drug misuse and 3% injury which was accidental and as a result of delusional beliefs.
4.62 Of the 165 people recorded as being at risk of harm to others, an incident of actual harm to others was recorded in 73% of cases. There were 264 recorded incidents of harm to others and in 71% actual violence occurred. Where specified, 9% of incidents were directed at strangers, 50% at family and friends, 21% to staff or other officials and 7% to property only. For 16% the instances of violence was classified as major or life threatening.

**Use of extended leave of absence by psychiatrists and in health board areas 1992-94**

4.63 An overall pattern of increase in use of ELOA applied to all health boards throughout the period examined (Atkinson et al. 1998). When looking at the percentage of people on section 18 on continuous LOA over 6 months, there was a variation in rank order between health boards from 1992-1994. However, only Highland was in the top 3 for all 3 years and Dumfries & Galloway and Fife appear twice. Of those with the least section 18 on ELOA, Ayrshire & Arran and Borders appear in all 3 years. There was little relationship shown between deprivation and use of ELOA. Although not showing significance, the direction of the association was that health boards of higher deprivation used ELOA less.

4.64 One psychiatrist in Tayside had 21 people on ELOA and this health board appeared as one of the greatest users. Greater Glasgow had the second highest user (14) and Lothian the third (10). Both are ranked lower than Tayside but had a greater pool of psychiatrists using ELOA. It may be that the individual consultants’ views on and experience of ELOA had the greatest impact on its use. Geography and provision of services may have played a part in consultants’ use of ELOA, but the study found that the use of ELOA was inconsistent in relation to population density. It was not possible to comment on the nature and extent of community facilities from the study’s data (Atkinson et al. 1998).

**Outcome for patients on leave of absence**

4.65 The most common outcome for patients on ELOA for between 6-12 months duration was discharge while those on ELOA for over 12 months were most likely to have the period extended with discharge the next most common option (Atkinson et al. 1999). In no health board was recall to hospital the most common option. However, of the 534 people who had at least one episode of ELOA 269 (50%) also had at least one episode of LOA of less than 6 months duration to a total of 594 episodes. Recall to hospital was the most common outcome of these episodes in 403 (68%) of cases.

**Patients on extended leave of absence in England**

4.66 There have been two studies in England which have looked at extended leave. One over the period 1983-1993 and another that deals only with pre 1986 data. It is worth remembering that community services, including support for families, have changed substantially in the 1990s and this may well effect both outcomes and the use of LOA.

4.67 Milton carried out a 10 year retrospective case note study on post-discharge section 17 patients which excluded those for whom it had been used for short term leave (Milton, 1998). During the period 1983-1993, section 17 was used 490 times. The number of patients involved is not given. This time span includes the time when LOA over 6 months was declared unlawful but no mention is made of this in analysis of the results.

4.68 The outcome of the section 17 is that 60% were allowed to expire, 19% were formally discharged by the RMO, 2% were discharged by a MHRT. There were 67 episodes (14%) of
recall for 61 patients after discharge. Section 3 admissions have risen during this time but the use of section 17 has remained proportionally the same. The number of patients on section 17 who have been recalled has significantly decreased (p<0.02).

4.69 Of the patients recalled 58% were men and 55% were over 35 years with 12% over 60 years. The diagnoses were: schizophrenia 52%, bipolar 12%, major depressive disorder 4.5%, miscellaneous (including drug-induced psychosis) 12% and for 19% a diagnosis was not given. Demographics of the population are not given, so it is not possible to tell whether these figures are proportional. The patients recalled were usually on a section 3 (84%) or section 37 (12%). Recall was within one week for 24% of patients, within one month for 55% and within 3 months for 81% of patients. Nobody was recalled in their final month or had the section renewed. Although the reason for recall “was not formally studied” Milton asserts that it was “almost universally linked to treatment non-compliance”.

4.70 There were no significant differences between those recalled and those not, but trends indicated that those recalled were more likely to have had at least 5 admissions, extensive contact (20+years) with psychiatric services or be discharged from a first admission (Milton, 1998).

4.71 Sensky et al looked at patients on extended leave in England pre 1986 (Sensky et al. 1991). This was a case note comparison study with patients of a similar age, sex and diagnosis but who did not require compulsory treatment in the community. This immediately involves a difficulty in making comparisons regarding outcome because the two groups are different on this fundamental issue which in itself is likely to be related to the measures used in the study. It can, however, tell us something about who the Act is used for. The study measures non-compliance with medication, non-compliance with outpatient appointments, loss to follow-up and dangerousness.

4.72 By contacting 26 hospitals, covering a wide range of psychiatric settings and services, Sensky et al found 42 episodes of extended leave, used by 10 psychiatrists. The number of patients was not given. Nineteen (73%) of the hospitals had not used extended leave which in itself seems surprising, but is not commented on. The mean period of extended leave was 116 weeks. Seventeen (40%) were on extended leave for one year or less, 12 (29%) for 1-2 years and 13 (31%) for more than two years. The average age for those on extended leave was 37.5 years (range 19-63), 57% were male, and 21% were married. There were no differences with the comparison group, bearing in mind an attempt had been made to match for age and sex.

4.73 Prior to extended leave 52% were living with their family, 62% had been at their current address for at least one year, 17% were employed within one month prior to admission, 48% had been unemployed for more than 3 years. Again there were no significant differences with the comparison group. The mean length of illness was 9.6 years (range 1-29 years), 33% had fewer than 4 admissions preceding the admission leading to this episode of extended leave, 83% had previous admissions under the Mental Health Act. There was a significant difference with the comparison group, 36% of the extended leave group had 4 or more admissions under the MHA compared with 14% of the comparison group. There were no differences in having a history of criminal charges; 29% of the extended leave group and 22% of the comparison group nor with a ‘lifetime’ history of dangerousness; 74% in the extended leave group and 65% in the comparison group.

4.74 There was, however, a significant difference in that patients currently on extended leave were more likely to have a recent episode of dangerousness (ie in the previous five years). This was 45% compared to 18% of the comparison group and in serious
dangerousness 31% of the extended leave group compared to 4% of controls. In the year previous to the most recent admission there is a significant difference in that 33% of the extended leave group had at least one episode of serious dangerousness compared to 4% in the comparison group (Sensky et al. 1991).

4.75 In the five years previous to the admission there was a significant difference between the groups in terms of full compliance with outpatient treatment. This was 5% of those in the extended leave group and 39% in the comparison group. This was also significant in the previous year for 9% of those on extended leave and 53% of those in the comparison group. In the year previous to admission 40% of the extended leave group and 2% of the control group were lost to follow up.

4.76 In the previous five years before the last admission those in the extended leave groups had spent an average of 35 weeks in hospital and those in the control group 23 weeks in hospital. There were no differences in the frequency of admission but there was a significant difference in the number of MHA admissions; 19% of the extended leave group and 53% of the comparison group had no MHA admissions.

4.77 Sensky and colleagues compared outcomes before and after extended leave but it is not clear how long this follow up period was for, nor how long the extended leave lasted making interpretation difficult. For 56% of patients there was a reduction in the number of admissions but admissions increased for 20%. Sixty-seven per cent of patients spent less time in hospital. Incidents of serious dangerousness fell from 24% to 5% and dangerousness fell in 22% of patients and increased in 2% (one case). There was no impact on dangerousness to objects or property. Compliance with outpatient attendance improved for 43% and deteriorated for 10%. The numbers attending outpatients rose from 17% to 51%. The authors report a “parallel rise” in compliance with medication but give no details.

4.78 Sensky et al picked out an interesting sub-group of patients; those whose extended leave was brought to an end as the result of the ruling of the court case and can thus be best described as a legal discharge rather than a clinical discharge. There were 13 patients in this group. They report that this group had poor outcomes. Two people committed suicide, 6 were admitted under MHA, 3 were lost to psychiatric follow up. This does not necessarily indicate poor outcome. They tell us that two years on a letter from housing about one of these “lost” cases suggested the patient was coping adequately. One patient was transferred to guardianship and is said to be doing OK and one patient continued to comply with medication and remains out of hospital. Compared with the other patients on extended leave there was a significant difference in compliance with outpatient appointments, with 27% of those who had a “legal end” complying with outpatient appointments at 6 months compared to 82% in those who had a “clinical end” to their extended leave. There was no difference in patient diagnosis or dangerousness.

4.79 Although a direct comparison of outcome would not be possible we are told nothing about the outcomes for the comparison group and thus have no way of knowing whether being on extended leave makes this group of generally more non-compliant patients more like those who comply or not. Dangerousness in this study was a global term and it is not possible to know whether this relates to patients being a danger to themselves or others. Not only do we not know which group it is used most for, we do not know if there is any difference in outcome.

COMMUNITY CARE ORDERS
4.80 The Mental Health (Patients in the Community) Act introduced supervised discharge in England and Wales and Community Care Orders in Scotland. Community Care Orders in Scotland allow the sheriff very wide ranging powers as to conditions, including where the person lives, whom they can see and where they spend their time. There is controversy over whether enforced medication is a legal option but our research indicates that it is included in a number of CCOs.
Consultants’ views prior to the introduction of community care orders in Scotland

4.81 Atkinson et al conducted a study immediately prior to the introduction of CCOs on consultant psychiatrists’ views on the proposed legislation to limit the use of LOA to 12 months (Atkinson et al. 1997). A total of 275 consultants (all those working in general adult psychiatry) were included except when they worked for the MWC. Of these 238 (86.5%) responded and 45 of these were excluded from analysis because they had retired or did not match the criteria, leaving 193 included in the analysis.

4.82 Consultants were asked whether they agreed to the limitation of LOA and the introduction of CCOs. On both counts they were emphatically against the proposals with 78% rejecting the limitation on LOA and 86% not in favour of the introduction of CCOs. 165 consultants confirmed that they used LOA and the predominant reasons given were, in 144 (87%) cases, the perceived threat of the patient stopping their medication and/or 139 (84%) lack of insight. The authors conjectured that consultants had simply omitted to give the reasons (that might follow on from lack of insight or medication non-compliance) that legally justified further detention in responding to this question.

4.83 The 40 consultants who used LOA, but not beyond a continuous period of 6 months were asked why they did not use it for an extended period. Sixteen (40%) responded that patients had an appropriate care plan and 10 (25%) had concerns about the legality of using LOA for the extended period. Only 6 consultants (3% of the total population) said that they would not use LOA beyond six months. Half of those that did not so use it said that they would consider it, the main reason anticipated being to ensure compliance with medication.

4.84 There was a highly significant difference in consultants’ opinions with regard to the proposed limit on the duration of LOA. Of the 40 consultants who used LOA, but not beyond a continuous period of six months, 16 (40%) were in favour of limiting LOA while of the 125 who had used LOA beyond this period only 22 (18%) were for this proposal. Length of time as a consultant also had an impact on the response to this issue with agreement increasing with experience (1-5 years 9%, 6-15 years 22%, over 16 years 40%) (Atkinson et al. 1997).

Use and perceptions of CCOs since their introduction & views on CTOs in Scotland

4.85 The 1997-98 MWC annual report commented on the low use of CCOs compared with use of ELOA and stated concerns about the use of these orders and the welfare of patients on them (Mental Welfare Commission for Scotland, 1998). The study on the use of ELOA found that numbers of people subject to this restriction increased dramatically over time (Atkinson et al. 1999). From 1988 the MWC introduced six monthly visits to all patients who had a continuous period of LOA over six months. This applied to 61 people in 1988 and 243 individuals in 1994 of which 22 people had been on LOA for over 12 months in 1988 and 129 by the end of 1994.

4.86 The MWC annual reports from 1996-98 note a total of 34 CCOs made during this fiscal period. Six were made and one was made and discontinued in the year 1996-97. Twenty-two were made and five were made and discontinued in the following year. The reasons for discontinuation of these six CCOs for the total period were given as: agreeable to continuing with programme of care (2); returned to hospital and detained under section 18 (2); non-compliant with depot and subsequently detained (1) and lapsed due to failure to renew (1). The report for 1998-99 recorded 14 CCOs made but provided no supplementary information.
4.87 The findings of Atkinson et al were extensively quoted by Dyer in a conference paper (Atkinson et al. 1997; Dyer, 1997). In this, he explored and discursively affirmed the appropriateness of the introduction of CTOs for maintaining the care of a “small but significant number” of patients in the community. This view was illustrated by the example of the considerable numbers of patients that had been maintained in the community under ELOA. The consultants’ overwhelming objection to CCOs on the grounds that they lacked the power to insist upon compliance with treatment and was also supported by reference to an earlier study of patients in England subject to ELOA (Sensky et al. 1991; Dyer, 1997; Dyer 1998). Sensky et al had concluded that the use of ELOA improved treatment compliance as well as reducing time spent in hospital and levels of dangerousness (see from paragraph 4.71 for full review of this paper).

4.88 Keay provided a legal perspective on this debate and also criticised CCOs because of their inability to insist on treatment (Keay, 1997). His main objection was that the grounds and processes involved in re-admission, in the event of non-compliance with medication and subsequent relapse, are overly restrictive. The design of CCOs were held to be overly cumbersome and this was projected as a deterrent to their use. By example, Keay illustrated that at least 13 different professionals would have to be contacted by the RMO in order to initiate and implement the order.

4.89 Scott reported the instance of one patient made subject to a CCO and, although light hearted in tone, his letter supported this factor (Scott, 1997). He cited the example of a socially isolated patient who had visits from responsible professionals, in pursuance of the CCO, in eight out the first ten days of its instigation. An “unexpected therapeutic benefit” from this extra socialisation was reported.

4.90 CCOs lack of clarity was also criticised by Keay (1997). He supported the view that three out of the seven CCOs made in 1996-1997 unlawfully documented the need for the patient to be compliant with medication as a condition of the order. A study of CCOs currently being completed at the University of Glasgow has also found instances of this occurrence (Atkinson et al. 2000). The possibility of local authorities or health boards being liable in the event of not providing services that a patient should subscribe to as a condition of their order was also indicated as a potential difficulty with CCOs (Keay, 1997).

Transfers to guardianship or community care orders from leave of absence in Scotland

4.91 Following the legislative introduction of CCOs the MWC noted that transfers from LOA to guardianship were very rare (Mental Welfare Commission for Scotland, 1997). In the fiscal year 1996-97, there were 11 transfers from section 18 to guardianship and 7 CCOs. The MWC noted that it appeared that guardianship was being considered as an alternative to CCO when LOA was not considered an option because of the 1995 Act.

4.92 The study on CCOs currently being conducted by the University of Glasgow has found an small, increasing number of people being transferred to guardianship from the maximum period allowed for LOA during this period. Only one patient was transferred to guardianship from LOA prior to restrictions on use and in the period 1988 - 94 (Atkinson et al. 1999).

SUPERVISED DISCHARGE

4.93 Supervised discharge, although not enforcing treatment can compel patients to live in a particular place and compel them to attend for treatment. Patients can be forcibly taken to mental health centres, the so-called ‘take and convey’ clause that has been widely opposed.
The Registrar of the Royal College of Psychiatrists described the Bill in its passage through parliament as “the worst of both worlds” in that people with mental illness would be subject to the powers of “arrest” to no apparent purpose. Harrison, on behalf of MIND, described the Bill as an “unworkable and destructive framework for community care”. Eastman and Peay in a BMJ editorial described the Bill as “anti-therapeutic…clinically unworkable and medico-legally flawed” (Eastman and Peay, 1998). Not everyone who disagreed with the provisions of the Act did so out of a concern for civil liberties. Many psychiatrists were concerned that that Act increased their responsibility for patients without giving them authority to enforce treatment.

4.94 The DoH has commissioned a major research study to examine the effectiveness of supervised discharge compared to guardianship. The results are not yet available. There are, however, several studies in England which have looked at the use of and aftercare under supervision or supervised discharge.

4.95 Mohan and Thompson in the South and West Region wrote to 453 doctors who could use supervised discharge, including psychiatrists, GPs, forensic examiners, and prison medical officers (Mohan and Thompson, 1998). They had a 62% (282) response rate. Of these 15 indicated they were not appropriate to use supervised discharge, 115 were consultants or RMOs and the other 152 were other categories of doctor. They only report results for the 115 consultants/RMOs. Nothing is said about why the others are ignored.

4.96 At six months after its introduction 47% of consultants had considered using supervised discharge but it had only actually been used by 13% (15). The reasons why it was not used (39 consultants) were lack of resources (11, 28%), increased paperwork (8, 21%), concern over litigation (5, 13%), the patient was recovering without its use (3, 8%) and uncertainty over the Act (2, 5%). The number who cite lack of resources is important since the Act requires the psychiatrist to show that the patient would benefit from supervised discharge by being enabled to receive the services they need. Some psychiatrists indicated that their services were inadequate.

4.97 There were no significant differences between those psychiatrists who did or did not use the Act. The views as to its usefulness were fairly evenly divided, including civil liberties issues, but the numbers involved are very small.

4.98 Of the 15 patients, all were on section 3 and 5 were on section 17. Thirteen had a diagnosis of mental illness and 2 were diagnosed with psychopathic disorder. Only 2 psychiatrists used the Act for people over 65 years (Mohan and Thompson, 1998).

4.99 The use of supervised discharge was looked at in Leicestershire Mental Health Services 18 months after the introduction of the Act (Davies and Bruce, 1999). At this time 22 had been subject to section 25 and there were 18 patients currently on supervised discharge. In comparison only 3 patients were on guardianship. The patients were predominately male (91%), had a mean age of 42 years, 15 (77%) had a diagnosis of schizophrenia, 2 (9%) had bipolar disorder, one (4.5%) had schizoaffective disorder and one (4.5%) had schizoaffective disorder with dementia. The mean number of previous admissions was 7.

4.100 Of the psychiatrists who could use the Act, 50% of general/rehab/forensic psychiatrists used it but only one out of 9 psychiatrists of old age. The mean number of people consulted with in the supervised discharge application was 5 (range 1-7) (e.g. patient, relative, GP). All psychiatrists commented on it being time-consuming and bureaucratic. That
health rather than social work was the lead agency in initiating supervised discharge was felt to be a factor in its wider use compared to guardianship. (see also from paragraph 5.13).

4.101 In the orders, all made conditions relating to compliance with treatment, 50% made conditions about residence and 59% made conditions about allowing access to supervisors.

4.102 Five of the patients had been on supervised discharge for at least one year. Of these 3 were renewed, one was discharged and one was compulsory admitted. Seven had been on supervised discharge for over 6 months of which 6 were renewed and one was allowed to relapse. Ten had been on supervised discharge for less than 6 months and all but one completed to date. For the patients over 6 months the average days out of hospital was 298 compared to 271 before, but the numbers are small and follow up limited. “Take and convey” had been used only once (Davies and Bruce, 1999).

HOSPITAL RESTRICTION ORDERS IN SCOTLAND

4.103 Following legislative changes restricting the use of LOA and the introduction of the CCO a study of forensic psychiatrists’ use of restricted hospital orders was conducted. This was to test fears that the limitations on periods of LOA may put pressure on psychiatrists to recommend additional restriction orders to prolong follow up (Humphreys and Gray, 1997). The removal of time limited restriction orders has emphasised the need for mental health grounds for this type of detention and the anticipation of an indefinite requirement for it (Criminal Procedure (Scotland) Act, 1995).

4.104 Thirty-nine psychiatrists were sent a postal survey of which was returned by 33 (85%) subjects. The population was all Scottish consultant forensic psychiatrists and others with a high degree of involvement in forensic practice. A substantial portion cited the ability to have further scrutiny of cases to ensure adequate follow up and the compulsion of treatment as additional reasons for imposing a restriction order on mentally disordered offenders. It was suggested that the use of restricted hospital orders and the reasons for imposing them should be monitored following the removal of compulsion to accept treatment represented by the replacement of extended LOA with CCO.

4.105 The figures for the use of restricted hospital orders from 1992-1999 in the MWC reports show a sharp increase in their use in the year 1994-1995 to a total of 18 orders (see table 4). There is a fluctuating trend in use thereafter with 18 being the extant figure in 1999. A previous study described a total population of 50 patients subjected to 51 restriction orders in the period 1989-1995 (Humphreys and Gray, 1996).
## Table 4  Character of episodes of detention under CPSA & MHSA

<table>
<thead>
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</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Remand to hospital before trial (CPSA)</td>
<td>153</td>
<td>38</td>
<td>186</td>
<td>38</td>
<td>170</td>
<td>36</td>
<td>180</td>
</tr>
<tr>
<td>Remand order/committal to hospital for enquiry (CPSA)</td>
<td>43</td>
<td>11</td>
<td>67</td>
<td>14</td>
<td>74</td>
<td>16</td>
<td>58</td>
</tr>
<tr>
<td>Interim hospital order (CPSA)</td>
<td>18</td>
<td>4</td>
<td>24</td>
<td>5</td>
<td>16</td>
<td>3</td>
<td>19</td>
</tr>
<tr>
<td>Not fit to stand trial or acquitted (CPSA)</td>
<td>4</td>
<td>1</td>
<td>12</td>
<td>2</td>
<td>6</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Hospital order without a restriction order (CPSA MHSA 60)</td>
<td>107</td>
<td>26</td>
<td>119</td>
<td>24</td>
<td>109</td>
<td>23</td>
<td>118</td>
</tr>
<tr>
<td>Hospital order with a restriction order (CPSA MHSA 62)</td>
<td>8</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>18</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Transfer order from prison before trial or sentence (MHSA 70)</td>
<td>25</td>
<td>6</td>
<td>33</td>
<td>7</td>
<td>27</td>
<td>6</td>
<td>39</td>
</tr>
<tr>
<td>Transfer direction from prison unrestricted order (MHSA 71)</td>
<td>21</td>
<td>5</td>
<td>14</td>
<td>3</td>
<td>17</td>
<td>4</td>
<td>27</td>
</tr>
<tr>
<td>Transfer direction from prison with a restriction order (MHSA 72)</td>
<td>29</td>
<td>7</td>
<td>26</td>
<td>5</td>
<td>26</td>
<td>6</td>
<td>33</td>
</tr>
<tr>
<td>Informal treatment as a condition of a Probation order</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>*</td>
<td>3</td>
<td>*</td>
<td>0</td>
</tr>
<tr>
<td>All episodes of detention</td>
<td>408</td>
<td>100</td>
<td>488</td>
<td>99</td>
<td>466</td>
<td>99</td>
<td>492</td>
</tr>
</tbody>
</table>
CHAPTER FIVE: GUARDIANSHIP

GUARDIANSHIP IN SCOTLAND

5.1 Guardianship orders are normally initiated by MHOs on behalf of people who have learning disability, dementia (including pre-senile dementia), Korsakof’s psychosis or mental illness. They specify that a person should reside in a particular place and accept such treatment and/or services as are deemed necessary for their well being. This should be through a formal process of needs assessment (McKay and Patrick, 1995).

5.2 The Mental Welfare Commission’s 1984 annual report noted that the number of people being received into guardianship “continued to decrease” and data from 1985-1992 reports indicate a fluctuating but downward trend in the application of guardianship orders. From 1993-1999 use has increased steadily and by increasingly greater numbers. At the beginning of 1993 the number of people on guardianship was 71 and this figure has risen by 148% to 176 at the beginning of 1999 with the greatest increase in numbers of approvals being in the period 1998-1999 (see table 5.1).

Table 5.1 number of people under guardianship

<table>
<thead>
<tr>
<th>Year</th>
<th>Start of year cases</th>
<th>Discharge (% decrease)</th>
<th>Approval (% increase)</th>
<th>+ or - End of year cases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>1985</td>
<td>73</td>
<td>27</td>
<td>37</td>
<td>15</td>
</tr>
<tr>
<td>1986</td>
<td>61</td>
<td>12</td>
<td>20</td>
<td>11</td>
</tr>
<tr>
<td>1987</td>
<td>60</td>
<td>24</td>
<td>40</td>
<td>21</td>
</tr>
<tr>
<td>1988</td>
<td>57</td>
<td>23</td>
<td>40</td>
<td>27</td>
</tr>
<tr>
<td>1989</td>
<td>61</td>
<td>31</td>
<td>51</td>
<td>14</td>
</tr>
<tr>
<td>1990</td>
<td>45</td>
<td>19</td>
<td>42</td>
<td>39</td>
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<tr>
<td>1991</td>
<td>65</td>
<td>25</td>
<td>38</td>
<td>31</td>
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<tr>
<td>1992-93</td>
<td>67</td>
<td>29</td>
<td>43</td>
<td>33</td>
</tr>
<tr>
<td>1993-94</td>
<td>71</td>
<td>31</td>
<td>44</td>
<td>41</td>
</tr>
<tr>
<td>1994-95</td>
<td>81</td>
<td>41</td>
<td>51</td>
<td>51</td>
</tr>
<tr>
<td>1995-96</td>
<td>91</td>
<td>53</td>
<td>58</td>
<td>67</td>
</tr>
<tr>
<td>1996-97</td>
<td>105</td>
<td>68</td>
<td>65</td>
<td>86</td>
</tr>
<tr>
<td>1997-98</td>
<td>123</td>
<td>92</td>
<td>75</td>
<td>99</td>
</tr>
<tr>
<td>1998-99</td>
<td>130</td>
<td>82</td>
<td>63</td>
<td>128</td>
</tr>
</tbody>
</table>

Calendar year reporting to 1991; fiscal year reporting 1992-1999
Adapted from MWC annual reports

Issues specific to diagnostic categories of people under guardianship

5.3 Unlike England, the Mental Health (Scotland) Act (MHSA) does not limit an application for guardianship by the need for a person to be abnormally aggressive and displaying seriously irresponsible contact as well as having a mental impairment (Grant, 1992; Whitworth and Singhai, 1995). Mental handicap (now usually referred to as ‘learning disability’) is explicitly included in the MHSA where it is not in the Mental Health Act 1983. The percentage of people on guardianship orders in Scotland, according to MWC figures, has decreased for those who are diagnosed as learning disability and increased for those with dementia to the point that there numbers are now very similar. However, patients with Korsakov’s psychosis (alcohol related brain damage) used to be included in the figures for dementia and they also represent an increasing population on guardianship orders (see table 5.2).
Table 5.2 diagnostic categories of guardianship cases

<table>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental handicap</td>
<td>49</td>
<td>69</td>
<td>46</td>
<td>57</td>
<td>52</td>
<td>42</td>
<td>47</td>
<td>36</td>
<td>56</td>
<td>32</td>
</tr>
<tr>
<td>Dementia including pre-senile</td>
<td>9</td>
<td>13</td>
<td>25</td>
<td>31</td>
<td>51</td>
<td>42</td>
<td>41</td>
<td>32</td>
<td>61</td>
<td>35</td>
</tr>
<tr>
<td>Alcohol related brain damage</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>16</td>
<td>32</td>
<td>18</td>
</tr>
<tr>
<td>Mental illness &amp; handicap</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Mental illness</td>
<td>9</td>
<td>13</td>
<td>5</td>
<td>6</td>
<td>17</td>
<td>14</td>
<td>30</td>
<td>16</td>
<td>25</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>71</td>
<td>100</td>
<td>81</td>
<td>100</td>
<td>123</td>
<td>101</td>
<td>130</td>
<td>101</td>
<td>176</td>
<td>100</td>
</tr>
</tbody>
</table>

Adapted from MWC annual reports

5.4 Re-incorporating the numbers for patients with Korsakov’s psychosis with those with dementia results in this combined category being far greater than learning disability by 1999 (93/53% v 56/32%). In terms of the use that is made of guardianship, this would seem to be a legitimate exercise. Indications are that a considerable number of guardianship orders are made primarily for the purpose of facilitating a residential or nursing home placement. The main reason for terminating guardianship is settlement into such placements and this occurs most frequently for patients with dementia or Korsakov’s psychosis (see table 5.3).

5.5 The Commission has also consistently expressed concerns that guardianship was being used inappropriately and, explicitly, in order to compel admission to hospital. The use of guardianship for the purpose of establishing a client in any placement setting can be delayed due to the problem of enforceability, specifically the lack of power to convey patients under a guardianship order. The absence of this power is generally acknowledged to be a problematical area by the MWC. However, they discuss it in their annual reports only in relation to the inability to convey clients to a place where they may be required to attend for treatment or to a day care facility. A guardianship order can compel a person to accept any treatment that is deemed necessary following their formal assessment of need (McKay and Patrick, 1995) however, the chapter on mental health legislation within Scottish Social Work legislation specifically confirms the absence of the power to convey under section 37 of the MHSA.

5.6 The absence of the power to convey may be the primary reason that guardianship is so rarely perceived as useful, and therefore sought, for the care of patients with mental illness. Although the number of people with mental illness placed on guardianship has increased over time these numbers are still very small and the percentage has remained fairly constant throughout (see table 5.2). The current study on CCOs and LOA shows a small, but increasing number of people have been transferred to guardianship from the maximum period allowed for LOA during the study period. Only one patient was transferred to guardianship from LOA prior to restrictions on use and in the period 1988-1994 (Atkinson et al. 1999; 2000). The ease with which a patient can be transferred from a section 18 (under LOA) to guardianship is administratively favourable especially when compared to the process of obtaining a CCO. Further discussion of this is contained in the section on CCOs from paragraph 4.9.
### Table 5.3 reasons for terminating guardianship

<table>
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<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>EPSD – residential/nursing home/at home care</td>
<td>11</td>
<td>37%</td>
<td>18</td>
<td>58%</td>
<td>58</td>
<td>18%</td>
</tr>
<tr>
<td>Mental handicap - no longer vulnerable</td>
<td>7</td>
<td>24%</td>
<td>6</td>
<td>20%</td>
<td>6</td>
<td>20%</td>
</tr>
<tr>
<td>Mental handicap - settled in residential care</td>
<td>1</td>
<td>4%</td>
<td>3</td>
<td>1%</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Mental illness - settled into residential care</td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>3%</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>All transfer to England</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>All lapsed by default</td>
<td>4</td>
<td>14%</td>
<td>1</td>
<td>3%</td>
<td>3</td>
<td>7%</td>
</tr>
<tr>
<td>All became hospital in-patient</td>
<td>4</td>
<td>14%</td>
<td>7</td>
<td>2%</td>
<td>2</td>
<td>3%</td>
</tr>
<tr>
<td>All death</td>
<td>2</td>
<td>7%</td>
<td>1</td>
<td>3%</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Total</td>
<td>29</td>
<td>100%</td>
<td>31</td>
<td>100%</td>
<td>31</td>
<td>100%</td>
</tr>
</tbody>
</table>

EPSD - elderly & pre-senile dementia including alcohol-related brain damage

* Includes 1 instance of unlawful detention

### Table 5.4 Pattern of guardianship by regions

<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
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<tr>
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<td>%</td>
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<tr>
<td>Strathclyde</td>
<td>13</td>
<td>23%</td>
<td>20</td>
<td>34%</td>
<td>16</td>
<td>35%</td>
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<td>40%</td>
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<tr>
<td>Lothian</td>
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<td>14</td>
<td>24%</td>
<td>9</td>
<td>20%</td>
<td>14</td>
<td>23%</td>
</tr>
<tr>
<td>Grampian</td>
<td>19</td>
<td>33%</td>
<td>16</td>
<td>27%</td>
<td>12</td>
<td>26%</td>
<td>12</td>
<td>19%</td>
</tr>
<tr>
<td>Tayside</td>
<td>5</td>
<td>9%</td>
<td>2</td>
<td>3%</td>
<td>3</td>
<td>7%</td>
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<td>2%</td>
</tr>
<tr>
<td>Fife</td>
<td>1</td>
<td>2%</td>
<td>1</td>
<td>2%</td>
<td>1</td>
<td>2%</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Highland</td>
<td>2</td>
<td>4%</td>
<td>4</td>
<td>7%</td>
<td>3</td>
<td>5%</td>
<td>5</td>
<td>8%</td>
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<tr>
<td>Shetland</td>
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<td>4%</td>
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<td>Western Isles</td>
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<td>0%</td>
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<td>Dumfries &amp; Galloway</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
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<td>0%</td>
<td>0</td>
<td>0%</td>
<td>2</td>
<td>3%</td>
</tr>
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<td>0</td>
<td>0%</td>
<td>0</td>
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</tr>
<tr>
<td>Total</td>
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<td>102%</td>
<td>59</td>
<td>101%</td>
<td>46</td>
<td>101%</td>
<td>62</td>
<td>102%</td>
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</table>

Percentages for totals do not add up to 100% due to rounding

* less than 1%

Adapted from MWC annual reports where regions are consistently maintained – end of fiscal year figures
Concerns expressed by the MWC regarding patients subject to guardianship orders

Pattern of use of guardianship by region

5.7 The total of the guardianship by region figures quoted in table 5.4 are the extant numbers for those years given in table 5.1. Missing years are due to the need to report regions consistently and are given as available in MWC reports. This table indicates that the trends in use for some regions are inconsistent with the national trend. Demographic influences are clear inasmuch as Strathclyde, the area with the greatest population density, consistently had the greatest numbers and percentage of people on guardianship orders per annum. Various other factors undoubtedly influence these figures but without the benefit of a comprehensive national survey on use further comment would have to be speculative.

5.8 The Commission’s 1985 report referred to their historical and ongoing concerns regarding the supervision and conditions of persons placed under guardianship but noted that the MHSA had introduced a welfare criteria under section 36(b). The Commission also noted that much of the control element of guardianship no longer applied under this revised Act and this was felt to be in keeping with the spirit of encouraging self-determination for such people. In 1986 the Commission sought views on guardianship preparatory to employing a full-time Social Work Commissioner to mount a special study of it commencing in 1988.

5.9 Deficiencies in the overall care being provided was consistently cited as a problem for people on guardianship. Several specific examples are given in the reports one of which was of a mentally handicapped young man who was discharged to a hostel placement then to home where he was found to be living in unacceptably poor domestic circumstances and subject to physical and verbal abuse from local boys. The responsible Social Work Department (SWD) cited staff shortages and other demands of higher priority. The commission has noted that cases of guardianship appear, in the view of some senior managers of SWDs, to command less priority than other statutory requirements.

5.10 The MWC continue to affirm the need for clear procedural systems in relation to the administration of guardianship. Areas of concern in this regard include:

- late applications for guardianship orders resulting in a detriment of care prior to the implementation of an order
- unplanned discharge due to the renewal date being overlooked
- instances of local authorities not consulting with the RMO
- local authorities not heeding RMO’s concerns prior to discharging an order.

5.11 The MWC consistently noted that local authority based guardians are not always clearly identifiable and are therefore not easily recognisable to the person subject to guardianship. The absence of a named local authority guardian is held by the MWC to create a lack of clarity concerning powers and responsibility. They also note that the MHO making the application may not have long term or close association with subject of the order. They recommend that there should be a care plan that would include the information on whom the effective guardian is the expectation of delegated responsibility.

5.12 Very few people are represented in court by a curator ad litem (CAL). A high number of people for whom an application for guardianship is made lack the ability to comprehend this proposal or its implications. The person subject to the application may be excluded from all or part of the court proceeding by certification that it would be prejudicial to their health or treatment. The sheriff should use the power to appoint a CAL in this case and may also do so
in any other circumstances. The MHO should also take responsibility to bring this to the attention of the court where it is deemed appropriate. The issue of whom pays for CAL is yet to be resolved. Until recently, a legal discrepancy between England and Scotland existed in that legal aid for CAL was not means tested in England as was the case in Scotland but this has now been amended.

GUARDIANSHIP IN ENGLAND

5.13 Guardianship in England increased by 6% between the end of March 1997 and 1998 and the extant figure was almost double that in the fiscal year ending 1992 (Mental Health Act Commission, 1999). The former increase was contrary to predictions that the introduction of supervised discharge would have considerable uptake and would replace guardianship in many cases (Burns, 1994). Both periods’ increases are broadly equivalent to the figure given by the MWC for Scotland (see table 5.1).

5.14 The Mental Health Act Commission noted that, since the approved social worker (ASW) had to make the guardianship order, RMOs had an incentive to prefer this over the order for the supervised discharge order which would be their responsibility to implement (Mental Health Act Commission, 1999).

5.15 The guidance in the new code of practice no longer represents an objection to guardianship’s use solely for the transfer of patients into residential care. It also emphasises the patient’s recognition of the authority of the guardian and that their co-operation with them is dependent on the patient’s level of capacity. A study that looked at guardianship in 4 different regions found that 18 (75%) of those subject to an order were elderly and all were female (Wattis et al. 1990). In 14 of these cases the order was used to move a patient into residential care from home and delays in so doing were common. One patient had to wait 2 years before the local authority implemented the order and the main recommendation of this study was that this should be clarified. Although this was a small study its findings were reflected in other published papers (Benbow and Germany, 1991; Gordon, 1998).

5.16 Some social services are perceived as being reluctant to pursue an order as a policy decision and, aside from the difficulties of transferring patients prior to the code of practice amendment, the reasons for this are unclear (Benbow and Germany, 1991). However, it is believed that many do so because of a deficit in resources (Ward, 1992). A survey of one health district’s psychiatry service for the elderly over a 2 year period found that the 32 patients who had 36 instances of recourse to the MHA had only one who was subject to a guardianship order (Morris and Anderson, 1994).

5.17 The impact of multi-agency assessment on the need for urgent action and powers to enforce this have been questioned (Gilmore et al. 1994). Guardianship in England is further limited in its application by the need for a person to be abnormally aggressive and seriously irresponsible conduct as well as having a mental impairment (Grant, 1992; Whitworth and Singhai, 1995). This last criterion does not apply under Scottish mental health law.

GUARDIANSHIP OUTWITH THE UK

The hogosha system in Japan

5.18 In Japan the Mental Hygiene Law was reformed in 1988 and renamed the Mental Health Law (Shiraishi, 1994). This new legislation established the Psychiatric Review Board
which gave patients the right to petition for release or improved treatment and required that doctors meet strict criteria before being granted the status of Designated Physician of Mental Health. Admission under voluntary status was established for the first time under this reformed law. The reformed legislation increased efforts to secure patient consent. Coupled with greater constraints on admission criteria this resulted in a rapid increase in voluntary admissions with a corresponding decrease in admissions for medical care and custody. Admissions under voluntary status were 20% in 1988 and had risen to 70% by 1992.

5.19 The hogasha system remained essentially unchanged, despite criticism, by the reformed law (Hemmi, 1989) and by a further review in 1993 (Shiraishi, 1994). Two main problematical areas in the hogasha system were identified. These were that the extensive powers of the hogosha infringed on patients’ rights and that they imposed too great a responsibility on the custodian to protect the community from the patient.

5.20 The law requires that all people that are defined as mentally disordered have a hogosha. Implicitly they remain under this custodial care unless they escape being so defined. Lay persons, either related to or in close interested contact with the mentally ill person, are frequently unwilling to take on the responsibilities required under this system in which case it falls to the local Mayor, as the last in priority, to fulfil this function.

5.21 The lay person hogosha has duties to the community which extend beyond regular law and include the responsibility to compensate parties in the event of personal injury or property damage perpetrated by the patient. A system of governmental compensation is recommended although it is suggested that this should be means-tested. The Mayor performs the function of a hogosha in form only and the move towards formalised and locally administered community mental health care was anticipated as being able to provide a more pro-active approach by Mayors or the substitution of an alternative system of non-lay person custodial care.

5.22 Hemmi recommends that their custodial powers over assets and their duty of care be returned to the patient when they are well. At that time, the hogosha had the power to allow abortion or sterilisation under the Eugenic Protection Law and it was recommended that these powers should be eliminated since they were in conflict with UN guidelines (Hemmi, 1989).

5.23 Hemmi argues that the hogasha should retain the right to consent to the patient’s admission for care and custody in the event of deterioration in their mental health without which a patient cannot be admitted. This is despite the broadly recognised fears that it would give rise to the development of an adversarial relationship (International Commission of Jurists, 1992). He counters that such a relationship more often arises due to the hogosha prolonging their custody of the deteriorating patient and becoming overburdened as a result. Hemmi is implicitly affirming that the hogosha may be adverse to engage in the role of providing their consent. Perhaps they also fear deterioration in their relationship with their custodian as a result?

5.24 Concerns that the hogosha could abuse this power are dismissed with the affirmation that the designated physician is the deciding agency and that the patient has the right to appeal against the decision (Hemmi, 1989).

5.25 The existence of a patient’s right to appeal does not, in itself, provide the encouragement or the ability to exercise that right. The attending doctor will presumably make their decision to admit a patient primarily on medical grounds but may also recognise the custodian’s need for respite. Taking account of this in the process of formal admission it may be seen as an abuse of consent. Conversely, if the hogosha is concerned about consenting to hospitalisation, this is not necessarily relieved by medical opinion agreeing that it is necessary.
Insofar as they address the issue, Hemmi’s arguments appear to affirm, rather than deny, that the requirement for a lay person to give their consent to psychiatric admission is problematical to both the custodian’s wellbeing and that of the patient.

5.26 The lay person’s reluctance to care for mentally ill relatives in their own homes and the lack of alternative accommodation has resulted in a protracted continuation of patients experiencing long-term care in institutions (Ishihara, 1982). Predating the new legislation, Ishihara’s study of families with mentally ill relatives in Japan found that relatives would overwhelmingly prefer that they remain in hospital especially when they had been there for an extended period. He found that, for the majority, this represented over 10 years continuous inpatient status. Of over 9,000 respondents to a survey of relatives of mentally ill people 64% were parents and 75% of these parents were over 60 years old (Japanese National Federation of Families with Mentally Ill Members, 1986). Coupled with this they also had an increasingly ageing in-patient population.

5.27 Japan has been subject to much criticism for its apparent reluctance to wholeheartedly embrace the process of deinstitutionalization but there are commentators that warn against implementing this without due planning of alternative resources and the maintenance of treatment standards in involuntary care (Lamb, 1994).

**Conservatorship in the United States of America**

5.28 Conservatorship—guardianship, conditional release and outpatient commitment are the three common models of supervised care in the community throughout the US with variable availability of each between states (Torrey and Kaplan, 1995). Outpatient commitment, varies considerably in different locales. It is widely available but relatively infrequently used. Where conservatorship is available in other states that do have a civil commitment statute conservatorship-guardianship is rarely used. The state of California does not have an explicit civil commitment statute and this form of guardianship is extensively used. Conservatorship is distinct from outpatient commitment in that it is based on substituted consent rather than civil commitment. Conservatorship in the US embodies third party consent to treatment and involuntary hospitalisation in the event of non-compliance with this treatment.

5.29 The Californian model of conservatorship is granted for a renewable period of one year and can be terminated before the date of expiry (Lamb, 1994). A menu of powers are available and granted according to need with a cognisance of providing the least restrictive options. The most common powers granted to the conservator relate to the conservatee cooperation regarding place of residence, involvement in treatment and the management of their finances. The system is presented in this paper as being a trade off whereby the conservatee maintains a level of independent living within the community where otherwise they would have to be institutionalised. The author affirms the need for conservatorship to be combined with professional case management.

5.30 Conservatorship is considered appropriate for people who are gravely disabled and this is defined as:

> “a condition in which a person, as a result of a mental disorder or impairment by chronic alcoholism, is unable to provide for his or her basic personal needs for food, clothing or shelter” (Lamb, 1994).

The case law interpretation in California holds that a person is not eligible if they have consistent and effective informal support and are able and willing to accept treatment that is deemed necessary.
5.31 Sixty psychiatric in-patients between the ages of 18 and 60 (median = 35 years), for whom a 30 day conservatorship order was granted were assessed for the subsequent four years (Lamb and Weinberger, 1992). This study sought to determine whether a further one year order was granted, the consequent stability of the patient and the existence or non-existence of informal support over the follow up period. Instability was considered according to incidences of psychiatric hospitalisation, acts of physical violence, arrests or homelessness.

5.32 The majority of all one-year orders granted begin with this initial period which is used to assess the patient’s needs and their appropriateness for conservatorship. A pre-arranged hearing then takes place and the court also reviews the case. The patient has the right of appeal to a jury or court trial but only in the event of the order being made. Conservatees also have the right to a judicial review of their order every 6 months.

5.33 Thirty-five (58%) were placed under a one year order at some point in the study period and 25 (42%) were not. There was no significant difference between these groups in terms of ethnicity, living and social circumstances, range of diagnoses, or past psychiatric history at the index point. The majority of the patients in the study had schizophrenia (45%) or affective disorder (38%) and many had a history of serious substance abuse (57%) and perpetrating physical violence (50%). The majority of them lived with their family (38%). For those placed on an extended order the average duration was 26 months.

5.34 The patients who were placed on conservatorship showed no significant difference in stability or instability and whether or not they had good family or other informal support. However, there was a highly significant relationship between the absence of family support and instability in the group that were not placed on a conservatorship order during the 4 years. Twenty-nine (83%) of those placed on the extended order maintained stability as long as it lasted. Twenty-one (60%) had their order terminated and only 9 (43%) of them maintained stability thereafter. Eight out of the 12 who became unstable did so within 6 months of the conservatorship order being terminated.

5.35 The presence of good family support and/or conservatorship were found to be closely related to stability, whereas the absence of either very much increased the likelihood of instances of extended duration in hospital, physical violence and homelessness (Lamb and Weinberger, 1992).

Guardianship in Australia

5.36 Substituted consent in the context of guardianship is well developed in a number of states in Australia. It is argued that this protects the patient, implicitly through their involvement with an advance directive. The guardian is also protected since they shoulder less negative responsibility for consent and the treatment provider is not responsible for giving consent (Rosenman, 1994). In Australia guardianship is being increasingly used as a protective system for people with disabilities other than mental illness. Rosenman gives this as an argument against having guardianship under separate mental health legislation since the needs addressed by it do not apply to all people with mental illness or exclusively to them.

5.37 A diagnosis of intellectual handicap is no longer the province of mental health legislation in Australia for whom, it is implied, guardianship is widely applicable. The granting of a guardianship order is thus perceived to be moving towards a needs rather than diagnosis-based decision.

Guardianship in Canada
The argument that the need for guardianship under separate mental health legislation is redundant is further explored by Gordon outlining the legislative changes in Canada (Gordon, 1993). The proposals of British Columbia’s Joint Working Committee on Adult Guardianship (1992) and mental health legislation, with regard to issues of consent to custody and treatment, are seen to be overlapping to a considerable degree. The proposals include the introduction of representative agreements which incorporate the concepts of advance directives. This would allow patients to instruct the guardian to give consent even when they are experiencing a period of incapacity and are not willing to submit to appropriate treatment (see also the section on advanced directives from paragraph 11.69). It was anticipated that guardianship orders should be time-limited and embody least restrictive options from a menu of care and supervision measures.
CHAPTER SIX: DETENTION IN SCOTLAND

PATIENTS’ KNOWLEDGE OF THEIR RIGHTS AND LEGAL STATUS

6.1 Knowledge of patients’ legal status and rights was studied through a survey of 111 subjects detained under sections of the MHSA or the Criminal Procedures (Scotland) Act (CPSA), at Carstairs State Hospital (Goldbeck and Mackenzie, 1997). This revealed a considerable lack of understanding in a significant proportion of the subjects.

6.2 The study subjects were from the 222 patients resident in Carstairs and were randomised to be representative with regard to gender and type of legal detention. One hundred and one (91%) were male and 10 (9%) were female, 46 (41%) were detained under the MHSA and 65 (59%) under the CPSA. Of those detained under the MHSA 27 (59%) were detained under section 18 and 19 (41%) were under a prison transfer order. The predominant diagnosis was of schizophrenia (68%) with a further (17%) having a primary diagnosis of learning disability. Of the total surveyed, only 27 (24%) were detained under section 18 of the MHSA and a discrete analysis of these patients was not provided. Added to, and aside from this, the findings cannot be readily extrapolated to patients detained under the MHSA in less secure institutions or within the community.

6.3 On admission, all patients routinely received a letter from the hospital explaining their legal status and 63 (57%) remembered receiving this. They were also given a booklet from the MWC, detailing issues of detention and legal rights, on admission and 42 (38%) remembered having seen one. Regarding verbal information, 66 patients (60%) did not believe their social worker, nurse keyworker or doctor had spoken to them about their legal rights under detention (Goldbeck and Mackenzie, 1997).

6.4 Of the 111 patients, 83 (75%) were unable to identify all three criteria for detention, 14 (13%) did not know that they were detained under a section of whom 70% were unable to identify the particular order. Eighteen (25%) were unaware that their detention had to be reviewed regularly and of those that did know this only 34% knew the correct frequency. Six patients (5%) did not know whom they would approach to appeal against their detention. One hundred and seven patients (96%) knew of the MWC but only 46% were aware of its protective role with regard to their welfare and rights. Thirty patients (27%) stated that they had never experienced contact with the MWC. Well-informed patients were more likely to have had contact with the MWC.

6.5 An awareness of the protective role of the MWC, having information from other patients about their rights or being familiar with hospital charter information were significantly more common characteristics in the 40 patients (36%) who had made at least one formal complaint. Of the 111 patients, 37 (33%) did not believe that they would treated fairly by complaints procedures.

6.6 Goldbeck and MacKenzie acknowledged the limitation on the study in that it was unable to ascertain whether patients who stated that they had not received information had in fact received it but were unable or unwilling to acknowledge this. It suggested further research into this that would include a formal process of patient education.

6.7 The MWC noted in their 1997-98 report that they had continuing concerns regarding hospital management’s fulfilment of their responsibility under section 110 to give information to patients and relatives about detentions and renewals of detention. They designated it as a
visiting theme for the forthcoming year (Mental Welfare Commission for Scotland, 1998). Accordingly, during their hospital visiting programme in 1998-99, the Commission asked 259 patients to complete a questionnaire regarding their knowledge of their detention. Two hundred and twenty three questionnaires were analysed because 16 were unable to respond due to their level of mental disturbance, 4 were voluntary patients and 6 were illegible.

6.8 The gender was unknown for 4 (2%) of the sample 174 (78%) were male and 45 (20%) were female. When asked if they were able to name the section that they were detained under 16 (36%) of the female and 94 (54%) of the male respondents were unable to do this.

6.9 During this period, the Commission visited a total of 648 patients in hospitals (including Carstairs) under its statutory duty to visit all patients who have been detained for over two years (304) and in response to patients’ requests (348). The number of analysed respondents is 40% of this available population.

6.10 There is a far greater percentage of males in the sample. This bias is probably reflected in the visited population as a whole since this includes a high proportion of patients detained at Carstairs State Hospital. It is not reflected in the gender breakdown of total detained patients by gender in any given year under sections 24, 26 and 18. We would expect a roughly even gender distribution in this population. The sum of all section routes in for patients detained in each year from 1992 to 1998 seem to indicate that rather more females than males are detained. However, these figures should be treated with caution. They may not be discrete values since it is unlikely that no patients had more than one detention episode in any year, for example section 24 to informal and a later episode of section 24 to section 26. (see table 6.1).

6.11 The results of the MWC survey reveal a considerable lack of knowledge of their rights in an extensive sample of detained patients visited by Commissioners. This is particularly disturbing given the high proportion of visits made to people who have been detained under sections of the MHSA for the lengthy period of over 2 years.

6.12 Bradley et al interviewed 40 patients detained under section 2 of the Mental Health (England and Wales) Act 1983 (equivalent to section 26 of the MHSA) on the penultimate day of this 28-day detention period (Bradley et al. 1995). Its findings revealed a lack of understanding of their rights most significantly among the 28 (70%) patients who did not wish to appeal against their order. After the interview 12 (43%) of them stated the intention to reconsider an appeal with 4 of these actually doing so.

6.13 This supports the Carstairs study’s findings that verbal communication (rather than written information) about these issues is more likely to be effective in facilitating patients awareness of their legal rights as well as their subsequent likelihood of exercising them (Goldbeck and Mackenzie, 1997). The 1998-99 MWC survey found that only 54% of the patients surveyed remembered being given written information and only 46% recalled a verbal explanation of their detention and rights accordingly. One fifth believed that they had been given no written information and one third no verbal guidance. Further discussion of these issues are in the section on patients’ knowledge of their rights from paragraph 11.28.
Table 6.1 Number of patients detained under MHSA sections 1992-98 by gender

<table>
<thead>
<tr>
<th>Year</th>
<th>Section 24 to discharge</th>
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<td>Female</td>
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<td>Female</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>1992-93</td>
<td>745</td>
<td>49</td>
<td>781</td>
<td>51</td>
</tr>
<tr>
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<td>704</td>
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</tr>
<tr>
<td>1997-98</td>
<td>772</td>
<td>47</td>
<td>868</td>
<td>53</td>
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</table>

Patients may have more than one category of section
Percentages are of total numbers within each section category
Adapted from MWC annual reports
PROFESSIONALS’ KNOWLEDGE OF PATIENTS’ RIGHTS AND LEGAL STATUS

6.14 Humphreys’ survey of junior psychiatrists revealed deficiencies in understanding of patients’ rights in relation to detention under section 24 (Humphreys, 1994). Forty junior psychiatrists were interviewed between October, 1991 and February, 1992. Few of them indicated the requirement that the patient must be in urgent need of care and almost none of the group was able to quote the provision that detention must be “urgently necessary for his health or safety or the protection of other persons”. Humphreys concluded that the ease of operation of the MHSA in respect of section 24 might encourage too rapid a resort to compulsory measures by junior psychiatrists.

6.15 A national survey of non-consultant psychiatrists’ knowledge of emergency detention procedures in Scotland was conducted as a follow on from this in a one in three random sample of all trainee and other non-consultant grade psychiatrists (Humphreys, 1997). All levels and grades of experience were represented in significant numbers including equivalent numbers of male to female senior registrars and an approximate ratio of three females to one male in other grades. The sample included 11 general practitioner trainees and the uptake rate was 94% with 101 doctors interviewed.

6.16 Senior registrars did rather better than other grades but otherwise seniority had little effect on the evident lack of knowledge. As regards the requirements that must be fulfilled in order to detain a patient in hospital, only 13% of all the practitioners were able to confirm that the health or safety of the patient or the protection of others was a criterion. Only 9% cited “urgent necessity”, 8% confirmed the need for no other alternative being available and 26% indicated the requirement that consent was required from a relative or MHO, where practicable. Only 7% were able to accurately define mental disorder within the MHSA and mental disorder as a prerequisite of detention was not identified in more than half of the respondents except in the senior registrar sample of whom slightly over 50% answered this question correctly.

6.17 None of the respondents were able to give an accurate description of all the criteria for emergency detention and a substantial numbers believed incorrectly that other conditions might preclude detention. These circumstances included: a patient being intoxicated with drugs or alcohol (30%); suffering from personality disorder or psychopathy (20%) or learning disability or intellectual impairment (8%). Regarding treatment, 17% believed that section 24/25 made specific provision for treatment and a further 22% were unclear or did not know about this.

6.18 Nearly 60% stated that they had not read the MHSA and the author noted that they mostly were unashamed of this. Also, few of those interviewed had had formal teaching in the application of emergency detention. It was speculated that these factors supported a view that there may be an underlying indifference to the wider issues of involuntary commitment such as civil rights versus social control and a proper concern to provide patients with appropriate treatment (Humphreys, 1997).

6.19 Significant lack of knowledge was evident in Humphrey’s study of consultant psychiatrists, though they did do better than more junior staff (Humphreys, 1998). Only 10% were able to give a correct definition of mental disorder, 3% were correct for conditions that were precluded from being sole grounds for detention, 13% were able to give all conditions that should be fulfilled in order to justify emergency detention, 20% correct for the effects of such an order and 40% for specific provision for “urgent treatment” in the Act.

56
6.20 Knowledge of civil commitment standards amongst GPs in Edinburgh was found to be in keeping with these findings (Humphreys and Ryman, 1996). From a one in four randomised sample 50 (18.3%) GPs in the area were asked questions only about matters that were considered essential to lawful emergency detention. The sample represented a wide range of age and experience with 19 (38%) having had some experience of psychiatry. The profile of non-participants’ experience was not determined but the authors conjectured that their initial approach might have discouraged those with a lesser understanding of statutory provisions. Most of those interviewed estimated that they used emergency powers of detention about once a year but 10 (20%) had detained 3 or more patients in the last 12 months.

6.21 It would have been interesting to know if these GPs had displayed a better understanding than the others, however the results showed a poor level of knowledge of detention procedures and understanding of statutory provisions overall. Forty two (84%) believed that emergency detention was intended to be the mainstay of compulsory care and 20 (40%) believed that treatment could be enforced under emergency detention. Regarding obtaining consent from a relative or MHO, 24 (48%) answered incorrectly. None of the GPs interviewed affirmed that compulsory detention would have to be for the health or safety of the patient, or the protection of other persons (Humphreys and Ryman, 1996). Similarly deficient levels of understanding of detention standards were found amongst GPs in a Masters degree thesis on the predominant use of section 24 discussed below (Keenan, 1999).

6.22 Psychiatrists’ knowledge of the law in recommending a restricted hospital order is questioned in relation to reasons being given which included ensuring follow up and continuing treatment (Humphreys and Gray, 1996).

6.23 The MWC conducted a survey regarding practise under section 110 of the MHSA in 1998. They asked 116 senior ward nursing staff what they would do in the event of a patient not understanding either written or verbal information delivered to them. Only 31% affirmed that this would result in discussion with an advocacy worker, a relative or the clinical team. Seventeen percent did not know what they might do under such circumstances.

CONSENT TO EMERGENCY DETENTION

6.24 The studies discussed above confirm a significant lack of knowledge regarding the need to obtain consent from a relative or MHO in detaining a person under an emergency section of the Act. Derring studied 100 patients admitted consecutively to the Royal Edinburgh Hospital in Autumn 1990 to compare differences in admissions with and without such consent (Deering, 1994). Twenty-eight patients were detained without consent and of the 72 cases where consent was obtained, 27 (38%) had the consent of the MHO and 45 (62.5%) had the consent of a relative.

6.25 Patient variables that biased towards detention without consent included aggression at the time of detention (68% v. 40%) and threats of violence (32% v. 13%). There was no significant difference in the actual acts of violence and instances of threats or acts of self-harm were also similar. Admission diagnosis between groups was similar, including the primary diagnosis of alcohol abuse or dependence although the presence of mental disorder was regarded as unlikely more often in non-consented patients (25% v. 10%).

6.26 Considerably fewer patients (21% v. 56%) in the non-consent group had their detention continued on to section 26 so that for 6 patients the legality of detention under subsequent longer term detention could have been open to question because of the failure to gain consent in the prior emergency intervention. This concern was consistently echoed in
MWC reports. Demographic data was similar for the 2 groups as was previous histories of psychiatric admissions including detention. The expectation that consent would be less likely to be obtained ‘out of hours’ was confounded since no difference was found when time of day was examined. Having had previous contact with the patient was more likely to result in consent (56% v. 32%) and case note information was more often available in consented detentions.

6.27 The reasons for not obtaining consent were cited as: difficulty in contacting MHO (2 cases 7%); emergency situation (16 cases 57%) and ignorance of the Act (ten cases 36%) including being unaware of MHO availability at night and ignorance of the existence of the MHO.

6.28 Comparison with the MWC figures on detention for 1990 reveals that this figure of 28% detentions without consent is more than twice the average for Scotland as a whole. Deering comments that this is of particular concern given the geographical advantages and greater availability of MHO cover than would be expected in more dispersed regions. However, the most recent MWC report (1998-99) which gives figures on non-consented detentions by regions and by hospital reveal nothing that could point to this being a conclusive factor. Deering found the same as the national average for detentions without consent under section 24 (14% v. 14%) as well as under section 25 (10% v. 12%).

6.29 A follow-up review of practise conducted by Deering between January and August 1992 compared favourably with the Scottish average (Deering, 1994). Several measures taken in response to the original study were believed to contribute to this change. These included increased education of junior psychiatrists and attaching information for guidance on section forms within the hospital. It is worth noting that this educational initiative was aimed solely at junior psychiatrists.

6.30 Psychiatrists’ knowledge of detention, investigated by Humphreys, found that senior registrars did rather better than other grades overall but otherwise seniority had little effect on the evident lack of knowledge (Humphreys, 1997). In response to a specific question regarding gaining consent as a requirement of detention, senior registrars (26%) and registrars (22%) did significantly worse than senior house officers (36%) in giving a response that was appropriate within the Act. In a national study of 72 consultant psychiatrists’ knowledge of mental health legislation only 13% were able to correctly identify all the conditions that must be fulfilled in order to detain a patient in an emergency (Humphreys, 1998). However, specific responses to the requirement for consent were not provided.

6.31 The MWC reports annually on instances of detention without consent by a relative or MHO. In a recent year, detention without consent for section 24/25 proceeded in 570 (13%) cases and for 20 (1%) episodes for section 26. The Commission wrote to medical practitioners with concerns that no adequate explanation was recorded as to why consent was not obtained. This accounted for 213 (37%) cases and replies indicated that a small but significant number of emergency detentions “may have been open to legal challenge”.

6.32 Recurrent reasons for not obtaining consent included:

- MHO refusing due to prior detention under nurses holding power (indicating a misunderstanding of the use of section 25:2)
- MHO not willing to consent due to feeling they are not able to properly assess the patient due to the patient being asleep or heavily sedated
- MHO refusing to give consent over the telephone
- Request for consent to section 26 being made too early in the section 24 period
difficulty in accessing MHO out of hours
GPs not having access to appropriate forms.

In the 1998-1999 annual report the MWC noted 303 (14%) instances of section 24 emergency detention applied without consent. They noted that, in the main, impracticality had been established on examination of the reasons given. In an additional 113 (30%) section 25-26 detentions the medical practitioners gave a clear account of possible risk to the patient or other persons in delaying the detention until consent had been obtained.

6.33 In the 1998-1999 period the Commission was able to produce information on detention without consent by hospital. Edinburgh Royal Infirmary had the highest rate at 30%. Eight others (County, Dykebar, Gartnavel General, Gartnavel Royal, Hairmyers, Queen Margaret and Rosynlee Hospital and Stirling Royal Infirmary) applied over 20% detentions without consent so that variations in detention without consent are not easily explained by the location of hospitals.

6.34 Throughout the MWC’s annual reports from 1984-1999, concerns are expressed regarding detentions that could be open to legal challenge. Keay, a lawyer, believes that there are no legal grounds for requiring patients to submit to treatment as a condition of their CCO. Instances of this have been discovered but with no legal consequence as a result (Keay, 1997). The possibility of legal challenge presupposes that a patient or carer would be able to discover that their detention is, or had been, illegally enforced but there is no statutory obligation for any professional individual or agency to inform them in this event. There is no information on patients being so informed routinely. Furthermore, anecdotal indications are that a climate of resistance to sharing this kind of information with patients and carers exists.

6.35 There is a legal requirement for form 9 (consenting to treatment) or form 10 (unable to consent or capable but refusing and visited by section 98 approved doctor) in cases of patients receiving drug treatment for over three months. The Commission, in the course of their statutory duty to visit detained in-patients during 1997-98 noted that medical and nursing staff did not have ready access to forms 9/10. Of the patients visited 80 (33%) were assessed by the commission visitor as not fully consenting. Of these 11 (14%) had a form 9 only. In 37 (16%) cases no form or other evidence of the patients consent status were found in the drug Kardex or medicine trolley therefore medical staff would have no knowledge of this or the limits of the treatment plan when they came to prescribe or administer drugs. Nursing and medical staff’s knowledge of the provisions of part X of the Act was assessed as at best patchy. Of the 239 nurses who were asked basic questions in relation to this, only 102 (42%) were able to answer all 4 questions correctly and 11 (5%) were unable to answer any of the questions.

THE PREDOMINANT USE OF SECTION 24

6.36 The MWC continue to voice concerns that applications for section 18 detention (without prior emergency detention) are very much in the minority (see table 6.2). This is particularly true for section 18 detention orders that are directly applied, without prior detention under section 24 or by the section 24 to section 26 route. The extant numbers for section 18 detentions in 1999 was 1054 (13% of all detention episodes). Of these only 181 (17%) were directly applied and not immediately preceded by a periods of detention under section 24 or 26 (see table 6.3). In their 1997-98 report the Commission commented that a number of apparently justified applications for section 18 detentions have been dismissed by courts because GPs have declined to fulfil their duty to provide the necessary report. They
recommended that GPs seek guidance from MHO or psychiatrist in filling in statutory required forms and that a process of application is begun in good time to allow the GP to arrange time, locum cover etc. in order to see the patient and attend the court.

Table 6.2 episodes of detention 1985-1999

<table>
<thead>
<tr>
<th>Year</th>
<th>Sections 24/25</th>
<th></th>
<th>Sections 26/26a</th>
<th></th>
<th>Section 18</th>
<th></th>
<th>Total Sections</th>
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<tr>
<td></td>
<td>N</td>
<td>%</td>
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<td>%</td>
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<td>%</td>
</tr>
<tr>
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<td>3186</td>
<td>66</td>
<td>1395</td>
<td>29</td>
<td>281</td>
<td>6</td>
<td>4862</td>
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<td>1986</td>
<td>3224</td>
<td>64</td>
<td>1531</td>
<td>30</td>
<td>291</td>
<td>6</td>
<td>5046</td>
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<td>1987</td>
<td>3375</td>
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<td>100</td>
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<td>1988</td>
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<td>61</td>
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<td>31</td>
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<td>8</td>
<td>5675</td>
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<td>59</td>
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<td>31</td>
<td>510</td>
<td>10</td>
<td>5172</td>
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<td>25</td>
<td>661</td>
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<td>5665</td>
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<tr>
<td>1992-93</td>
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<td>32</td>
<td>745</td>
<td>11</td>
<td>6558</td>
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<tr>
<td>1993-94</td>
<td>3696</td>
<td>55</td>
<td>2157</td>
<td>32</td>
<td>823</td>
<td>12</td>
<td>6676</td>
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<td>1994-95</td>
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<td>48</td>
<td>3016</td>
<td>39</td>
<td>877</td>
<td>11</td>
<td>7653</td>
<td>98</td>
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<tr>
<td>1995-96</td>
<td>4151</td>
<td>56</td>
<td>2398</td>
<td>32</td>
<td>886</td>
<td>12</td>
<td>7435</td>
<td>100</td>
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<tr>
<td>1996-97</td>
<td>4115</td>
<td>56</td>
<td>2416</td>
<td>33</td>
<td>887</td>
<td>12</td>
<td>7418</td>
<td>101</td>
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<tr>
<td>1997-98</td>
<td>4333</td>
<td>55</td>
<td>2527</td>
<td>32</td>
<td>970</td>
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<td>2581</td>
<td>32</td>
<td>1054</td>
<td>13</td>
<td>7991</td>
<td>100</td>
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Calendar year reporting to 1991; fiscal year reporting 1992-1999
Percentages for totals do not add up to 100% due to rounding
Adapted from MWC annual reports

6.37 The three previously discussed studies regarding general practitioner, consultant and non-consultant psychiatrists’ knowledge of the Act revealed an attitudinal bias against section 18. In response to the question “which section should be the mainstay of formal detention”, 83% of consultants answered correctly to section 18 (Humphreys, 1998), as did 48% of senior registrars, 26% of registrars, 21% of senior house officers (Humphreys, 1997) and 16% of a one in four sample of general practitioners surveyed in Edinburgh (Humphreys and Ryman, 1996).

6.38 Keenan’s Masters thesis explored the predominant use of section 24 and analysed respondent general practitioners (63), consultant psychiatrists (7) and mental health officers (14) views on section 24 in relation to section 18 (Keenan, 1999). Additionally, case study investigations of the perspectives of patients detained under section 24, their relatives and the relevant admitting doctor were conducted. The study area of North Lanarkshire’s heavy use of section 24 over section 18 statistically reflected the national use (see table 6.2) as detailed in MWC reports.

6.39 Health or safety of the patient or the protection of others was the most frequently selected grounds for emergency detention for all practitioners surveyed. Consideration of undesirable delay in processing a section 18 application was a factor for 52% of the GPs, 85% of the Mental Health Officers (MHOs) but only 28% of the psychiatrists. The majority of all the practitioners held that section 24 should be used to detain patients where they were not compliant with informal status. However, 24% of the GPs, 29% of the consultant psychiatrists and 29% of the MHOs did not consider these as primary reasons for using section 24.

6.40 The MWC reports from 1992-99 indicate consistently that at least 40% of all section 24 detentions result in discharge to voluntary status (see table 6.4). This raises the question
that admissions initially under voluntary status may not be as rigorously sought as they should be in all cases.
Table 6.3 Routes to episodes of section 18 detention orders

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>From s24 to 26 to s18</td>
<td>626</td>
<td>84</td>
<td>690</td>
<td>84</td>
<td>765</td>
<td>87</td>
<td>781</td>
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<td>From s24 to s18</td>
<td>1</td>
<td>*</td>
<td>2</td>
<td>*</td>
<td>7</td>
<td>*</td>
<td>2</td>
</tr>
<tr>
<td>Direct to s18</td>
<td>118</td>
<td>16</td>
<td>131</td>
<td>16</td>
<td>105</td>
<td>12</td>
<td>103</td>
</tr>
<tr>
<td>Total episodes resulting in s18</td>
<td>745</td>
<td>100</td>
<td>823</td>
<td>100</td>
<td>877</td>
<td>99</td>
<td>886</td>
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</table>

Table 6.4 Routes from episodes of section 24 detention orders

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</tr>
</thead>
<tbody>
<tr>
<td>From s24 to discharge</td>
<td>1652</td>
<td>44</td>
<td>1560</td>
<td>42</td>
<td>1466</td>
<td>40</td>
<td>1751</td>
</tr>
<tr>
<td>From s24 to s26 to discharge</td>
<td>1454</td>
<td>39</td>
<td>1444</td>
<td>39</td>
<td>1432</td>
<td>39</td>
<td>1617</td>
</tr>
<tr>
<td>From s24 to s26 to s18</td>
<td>626</td>
<td>17</td>
<td>690</td>
<td>19</td>
<td>765</td>
<td>21</td>
<td>781</td>
</tr>
<tr>
<td>From s24 direct to s18</td>
<td>1</td>
<td>*</td>
<td>2</td>
<td>*</td>
<td>7</td>
<td>*</td>
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<td>Total s24 episodes</td>
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<td>3696</td>
<td>100</td>
<td>3670</td>
<td>100</td>
<td>4151</td>
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</table>

Table 6.5 Detention episodes & all patients detained under the CPSA and MHSA by gender

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Male patients</td>
<td>227</td>
<td>86</td>
<td>240</td>
<td>83</td>
<td>237</td>
<td>84</td>
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<tr>
<td>Female patients</td>
<td>38</td>
<td>14</td>
<td>50</td>
<td>17</td>
<td>46</td>
<td>16</td>
</tr>
<tr>
<td>Total patients</td>
<td>265</td>
<td>100</td>
<td>290</td>
<td>100</td>
<td>283</td>
<td>100</td>
</tr>
<tr>
<td>Total episodes</td>
<td>408</td>
<td>100</td>
<td>488</td>
<td>100</td>
<td>466</td>
<td>100</td>
</tr>
</tbody>
</table>

Adapted from MWC annual reports
* less than 1%
6.41 As regards the main features of section 24 admission the existence of an emergency situation requiring immediate action was overwhelmingly the predominant choice for all practitioners. Regarding the GP views on the other main features, “pressure from the family” was identified in 50% of these respondents and “difficulties within the family caused by the patient” accounted for 42%. “Lack of an alternative setting for the patient” was chosen by 38% and “lack of respite care and support” was selected by 26%.

6.42 Keenan concludes that section 24 is not being used for purposes other than under emergency circumstances since in 93% of cases this is given as the main feature. However, it would have been interesting to know how many GPs selected at least one of these options. This may have given a considerably greater than 50% indication of lack of viable alternatives to hospitalisation being a factor in using section 24. Methodological problems may have caused respondents to neglect to indicate all the options relevant to the detention and further knowledge of these would have been useful.

6.43 The major reason for preferring section 24 for all practitioners was the length of time it takes to process section 18. The majority of the GPs also held that the process for making a section 18 application was too complicated, that they did not have the knowledge and experience to undertake it and would anticipate difficulties in obtaining the necessary medical recommendations and specialist psychiatric assistance in pursuing it. Only a third of the GPs thought that being able to use section 18 before the patient deteriorated represented a benefit (Keenan, 1999).

6.44 When the MHOs were asked their views on the use of section 24 they highlighted concerns in this area regarding GPs knowledge and experience. They also highlighted concerns about patients’ rights and that they felt GPs involved them in this process for little more than “rubber stamping”, the decision to enforce section 24 having already been made by the GP. The MHOs, in the majority, preferred to obtain consent. Some commented that they felt that their ongoing relationship with the family could be jeopardised otherwise. The MHOs especially objected to the lack of appeal under section 24.

6.45 Approximately half of all the practitioners indicated their belief that section 18 was too long a period of compulsory detention in the first instance. This appears to disregard the fact that it can be discharged as soon as it is considered appropriate. Practitioners’ viewpoints regarding the appropriateness of the sheriff’s involvement in the decision to detain under section 18 was inconclusive. The two questions that addressed this factor produced contradictory opinions. A significant proportion of the psychiatrists (42%) believed that distress to the patient through involvement in the court procedure was an issue but this did not feature highly for the GPs or the MHOs (Keenan, 1999).

6.46 It may be that concerns about sheriffs’ lack of dedicated knowledge and experience is also a factor here although it was not addressed in this work. Keay has suggested that scope exists for a pool of sheriffs dedicated to mental health issues to address inconsistencies in knowledge and practise (Keay, 1997).

6.47 Practitioners were asked to indicate positive features of section 18 and the predominant response from them all was that it provided greater protection of patients’ rights however, only 46% of the GPs affirmed this. Only 23% of the GPs held that the greater involvement of the patient in the process was of merit whereas 57% of the psychiatrists and 71% of the MHOs affirmed this (Keenan, 1999).

6.48 The 15 case studies intended to examine the A1 form for section 24, the admitting doctor’s questionnaire and to conduct interviews with the patient and their relevant nearest
relative. Only 5 of these studies achieved completion of all 4 components. All of the 15 achieved the examination of the A1 form and completed a patient interview. However, the author acknowledged that the choice to interview the patient while still within the ward environment may have inhibited patients’ responses and that some were still acutely unwell and therefore not optimally suitable for interview. Perhaps because of this, and the fact that only 7 relative interviews were achieved, no summary of the patient and/or relative perspective was provided.

6.49 The responses of the admitting doctors (12/15) and the examination of the A1 forms broadly supported the findings of the practitioners’ survey. The GPs lack of experience in pursuing a section 18 was not consistent but was a feature in 4 cases. Consent for detention was consistently pursued from either the MHO in 6 cases or the nearest relative in 7 cases (Keenan, 1999).

DETENTION UNDER THE CPSA & MHSA PART VI

6.50 The combined tables for detentions under these categories in the MWC reports show a ratio of patients to episodes that is similar throughout 1992-98 (see table 6.5) The annual report for 1998-99 only gives the total number of episodes which is 468 so figures are not included for this. Considerably more males (82% extant 1998) than females are detained under sections of the CPSA and MHSA per annum and this to has been consistent over time.
CHAPTER SEVEN: SECURE PROVISION IN SCOTLAND

INTENSIVE PSYCHIATRIC CARE UNITS

7.1 Unlike England, Scotland retained many of its locked facilities as Intensive Psychiatric Care Units (IPCUs) since the progression of the open door policy (Bell, 1955). This resulted in an under-provision of secure facilities south of the border which was addressed by the provision of dedicated Regional Secure Units. Smith looked at medium secure facilities and identified 15 locked wards or units in Scotland of which 14 responded to a survey (Smith, 1997). The conclusions were that they had an important role in secure provision and risk management but noted some areas of concern.

7.2 The majority of the units were not purpose built. Twelve were converted wards in buildings that were at least fifty years old. The secure facilities provided were variable. Four (28%) had no security features other than being locked and 50% had no form of personal alarm system for staff. Only one unit stipulated the need for a patient to be formally detained as a criterion for transfer. In 11 (79%) of the units up to 15% admitted in the preceding year were informal in-patients on transfer and one unit reported 46% with this status during that period. Many units had no written guidelines on transfer procedure and only 50% had a policy of designating staff to assess patients’ appropriateness for transfer on the open ward prior to the event (Smith, 1997).

7.3 At that time, only 4 (28%) of the units had segregated areas for males and females. The MWC has consistently expressed concerns regarding the lack of appropriate gender segregation in psychiatric hospitals as a whole. They noted that this was especially evident in contracting or closing down institutions.

Characteristics of IPCU patients

7.4 The most frequent reasons for referral to the IPCUs discussed by Smith was physical violence to others (in 5 units), risk of absconding (4), disruptive behaviour (3) and self harm (2). Most patients in all the 12 units had an admission diagnosis of schizophrenia followed by affective disorders and then drug or alcohol-induced psychosis. Consultants estimated that, on average, 75% of their patients were male (Smith, 1997). The characteristics of in-patients transferred to the IPCU in the Royal Edinburgh Hospital during 1993 broadly echoed these predominant reasons for referral, diagnoses and gender bias in Smith’s national study (Smith and Humphreys, 1997).

7.5 Smith and Humphreys examined the case-notes of the 97 patients transferred to the IPCU unit in the Royal Edinburgh. They accounted for 131 transfer episodes over the one-year period. Physical violence to others was the predominant reason for transfer accounting for 39 (30%) of the recorded episodes. Verbal assault or threatening behaviour was the reason in 22 (17%) of cases and generally disruptive behaviour accounted for 21 (16%) of the transfers. The second most common reason for transfer in 25 (19%) episodes was attempted absconding. The gender bias towards male patients as a whole (66%) was echoed in all reason for transfer categories except self-harm which accounted for 16 (12%) of all patients.

7.6 Most patients (51%) had an admission diagnosis of schizophrenia with hypomania/mania the next most common at 23%. Patients with affective disorder were predominantly transferred by reason of generally disruptive behaviour and the 11 (8%) patients...
who were diagnosed as having personality disorder were mainly women who were transferred because they had been self-harming. No males with personality disorder were admitted to the IPCU because of physical violence to others.

7.7 Twenty-six (20%) of the patients had informal status on the open ward and none of these were subsequently detained during their admission period on the IPCU. Most of the patients (70%) stayed in the unit for less than two weeks with a further 23% having an admission of less than twenty-four hours. Fourteen (11%) had an admission to the IPCU of longer than a month (Smith and Humphreys, 1997)

STATE HOSPITAL PATIENTS

7.8 The MWC consistently expressed concerns about delays in transferring patients no longer requiring high security in Carstairs State Hospital. At a meeting with the hospital in December 1997 30 people were reported as being on a transfer list for over 3 months. Three men with learning disabilities were considered fit to leave in 1995 but were still there at that time. Lack of forensic facilities in relevant health board areas were cited as the main reason for lack of progress in addressing this issue. This finding was supported by a recent review of the State Hospital (Thomson et al. 1998). It was discovered that 75% of the patients about to be discharged could have been discharged earlier had a medium secure unit or local hospital place been available. Fifty percent of the patients admitted to the hospital were assessed by their RMO as not being in need of high security management. Most of these patients are admitted from the criminal justice system rather than from mental health services.

7.9 The population of the State Hospital increased from 200 patients in 1993 to 242 in 1998 and has continued to escalate since. Trends in the criminal justice and mental health systems and increases in drug-related crime are also cited as having a relationship with this increase (Thomson et al. 1998).
CHAPTER EIGHT: MORTALITY & MORBIDITY IN SCOTLAND

MENTAL WELFARE COMMISSION SUICIDE STATISTICS

Risk assessment, communication and management

8.1 The MWC noted in its 1997-98 report that the extent to which risk assessment, communication and management play a part in the diagnostic and treatment process appears to be variable. They recommended greater standardisation of procedures and communication of risk factors. The breakdown for figures in table 8.1 should be treated with caution as factors of possible under-reporting to the Commission in any given year and the time-lapse may mean that some instances of suicide actually took place in the preceding year. However, the very much higher instances of suicide for patients that are being cared for within the community has implications for risk assessment, communication and management given the relatively lesser degree of supervision that such patients can be afforded. There was no information given for incidences of suicide in the most recent annual report.

Table 8.1 Suicides reported to the MWC 1994 - 98

<table>
<thead>
<tr>
<th>Year</th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>1994-95</td>
<td>24</td>
<td>52</td>
<td>68</td>
<td>28</td>
<td>76</td>
</tr>
<tr>
<td>1995-96</td>
<td>15</td>
<td>46</td>
<td>75</td>
<td>24</td>
<td>61</td>
</tr>
<tr>
<td>1996-97</td>
<td>32</td>
<td>55</td>
<td>63</td>
<td>28</td>
<td>87</td>
</tr>
<tr>
<td>1997-98</td>
<td>26</td>
<td>66</td>
<td>72</td>
<td>28</td>
<td>92</td>
</tr>
</tbody>
</table>

Adapted from MWC annual reports

8.2 In the 1998-99 MWC report, information about the patient’s most recent assessment of mental state was only reported in a third of the cases. Twenty percent of those where it was reported were thought to have improved. In previous reports the commission has noted a high incidence of patients with an improved clinical profile prior to suicide. This is in keeping with the generally acknowledged equation between improvement in functioning and mental state and this increased risk for severely mentally ill patients over a range of diagnoses. For example, the return of insight following relapse in schizophrenic illness is known to heighten the risk of experiencing a lowering of mood and/or harm to self, including suicide. There is evidence from research in England that patients are at a high risk of suicide shortly after discharge (Appleby, 1992).

8.3 The assessment of risk in clinical practice is of particular interest to the National Confidential Enquiry into Suicide and Homicide by People with Mental Illness and they hope to be able to make recommendations to improve this (Amos et al. 1997). This ongoing study hopes to expand into Wales, Northern Ireland and Scotland.

8.4 The MWC has also noted suicides that coincide with a period of transfer or transition and this is not, in some cases, one that is expected to produce a negative effect on the patients’ well being. For example, they cite instances where patients are moving to supported accommodation after a period of unsettled domestic circumstances. Significant change is acknowledged as being especially arduous for people with severe mental illness.
Characteristics of patients

8.5 Schizophrenia continued to be reported as the dominant diagnosis of all suicide cases reported to the Commission. Outpatient and male suicides represent the highest percentage reported and young men especially were consistently represented as the predominantly vulnerable group. Twenty-seven (42%) of the total (64) male suicides reported in 1997-98 were under the age of 35. This reflects national statistics and there is a higher proportion of young men detained under MHSA with severe mental illness.

8.6 Of the total 4310 detentions in 1997-98 (under sections 24, 26 and 18) 982 (23%) were males under the age of 35 compared to 744 (17%) females for this age group. Of the total 970 detentions in 1997-98 under section 18, there were 240 (25%) males under the age of 35 compared to 162 (17%) females in the same age group (see tables 8.2-8.4). In this year’s reporting, the commission noted that a current history of drug and/or alcohol abuse (36 patients and also 4 patients with a history of, though not current abuse) and significant life events (55 patients) were noted as an increasing factor.

8.7 In collecting data on suicides in England the National Confidential Enquiry into Suicide and Homicide by People with Mental Illness prioritised current inpatients, patients within three months of discharge, those under the Care Programme Approach, ethnic minorities, patients who did not attend or were non-compliant (Amos et al. 1997).

PSYCHIATRIC MORBIDITY

8.8 Cavanagh and Shajahan identified increasing rates of first admission to hospital for men with major mental health illnesses and explored links with an increase in psychiatric morbidity and mortality (Cavanagh and Shajahan, 1999). Data on first admissions to mental health units in Scotland between 1980 and 1995 revealed an increase in admissions with a diagnosis of paranoid states and non-organic psychosis. This was most dramatically so in young men and women but especially so in young men. In the diagnostic category of affective disorder the overall admission rate fell for women and was unchanged for men. However, there was an increase for women in the under twenty-five age group and greater increase for men in both the 15-24 and the 25-39 age ranges. Substance abuse is greatest amongst younger adults, especially the 15-24 year age group, and that this may be a confounding variable. It is unknown whether this was increasingly a problem for women as well as men.

8.9 Reviewing the literature, Cavanagh and Shajahan note that the decreased admission rate for women with schizophrenia during this period (while numbers remained constant for men) may be due to the narrowing of diagnostic criterion which has tended to exclude women. Generally the falling or constant rates of admission for all diagnostic categories outwith the under 25 age grouping may point to a causal relationship with changing gender role-related features within the younger age range.

8.10 Recent dedicated studies on suicide in Scotland both nationally (Pounder, 1991) and focussed on the Lothian region (Squires and Gorman, 1996) found that suicide amongst young men has undergone a dramatic increase in recent years.
Table 8.2 number of people detained under section 24 and discharged to informal by age group and gender

<table>
<thead>
<tr>
<th>Year (num)</th>
<th>24 years or younger</th>
<th>25 – 34 years</th>
<th>35 – 44 years</th>
<th>45 – 64 years</th>
<th>65 years or older</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>92-93 (1526)</td>
<td>107 7</td>
<td>79 5</td>
<td>189 12</td>
<td>170 11</td>
<td>154 10</td>
</tr>
<tr>
<td>93-94 (1430)</td>
<td>118 8</td>
<td>79 6</td>
<td>165 12</td>
<td>172 12</td>
<td>107 7</td>
</tr>
<tr>
<td>94-95 (1345)</td>
<td>128 10</td>
<td>91 7</td>
<td>181 13</td>
<td>169 13</td>
<td>135 10</td>
</tr>
<tr>
<td>95-96 (1602)</td>
<td>130 8</td>
<td>97 6</td>
<td>214 13</td>
<td>209 13</td>
<td>157 10</td>
</tr>
<tr>
<td>96-97 (1550)</td>
<td>119 8</td>
<td>114 7</td>
<td>197 13</td>
<td>193 12</td>
<td>146 9</td>
</tr>
<tr>
<td>97-98 (1640)</td>
<td>136 8</td>
<td>103 6</td>
<td>218 13</td>
<td>222 14</td>
<td>165 10</td>
</tr>
</tbody>
</table>

Table 8.3 number of people detained under section 24 to 26 and discharged to informal by age group and gender

<table>
<thead>
<tr>
<th>Year (num)</th>
<th>24 years or younger</th>
<th>25 – 34 years</th>
<th>35 – 44 years</th>
<th>45 – 64 years</th>
<th>65 years or older</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>92-93 (1454)</td>
<td>97 7</td>
<td>74 5</td>
<td>182 13</td>
<td>165 11</td>
<td>107 7</td>
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<tr>
<td>93-94 (1444)</td>
<td>148 10</td>
<td>94 7</td>
<td>174 12</td>
<td>148 10</td>
<td>87 6</td>
</tr>
<tr>
<td>94-95 (1432)</td>
<td>126 9</td>
<td>79 6</td>
<td>193 13</td>
<td>168 12</td>
<td>109 8</td>
</tr>
<tr>
<td>95-96 (1617)</td>
<td>141 9</td>
<td>82 5</td>
<td>210 13</td>
<td>216 13</td>
<td>109 7</td>
</tr>
<tr>
<td>96-97 (1652)</td>
<td>138 8</td>
<td>86 5</td>
<td>219 13</td>
<td>199 12</td>
<td>122 7</td>
</tr>
<tr>
<td>97-98 (1700)</td>
<td>159 9</td>
<td>87 5</td>
<td>229 13</td>
<td>170 10</td>
<td>142 8</td>
</tr>
</tbody>
</table>

Table 8.4 number of people detained under section 18 by age group and gender

<table>
<thead>
<tr>
<th>Year (num)</th>
<th>24 years or younger</th>
<th>25 – 34 years</th>
<th>35 – 44 years</th>
<th>45 – 64 years</th>
<th>65 years or older</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>92-93 (745)</td>
<td>51 7</td>
<td>48 6</td>
<td>123 17</td>
<td>94 13</td>
<td>77 10</td>
</tr>
<tr>
<td>93-94 (823)</td>
<td>90 11</td>
<td>51 6</td>
<td>152 18</td>
<td>85 10</td>
<td>68 8</td>
</tr>
<tr>
<td>94-95 (877)</td>
<td>107 12</td>
<td>52 6</td>
<td>158 18</td>
<td>112 13</td>
<td>70 8</td>
</tr>
<tr>
<td>95-96 (886)</td>
<td>112 13</td>
<td>39 4</td>
<td>155 17</td>
<td>112 13</td>
<td>69 8</td>
</tr>
<tr>
<td>96-97 (887)</td>
<td>88 10</td>
<td>41 5</td>
<td>163 18</td>
<td>83 9</td>
<td>90 10</td>
</tr>
<tr>
<td>97-98 (970)</td>
<td>92 9</td>
<td>57 6</td>
<td>148 15</td>
<td>105 11</td>
<td>99 10</td>
</tr>
</tbody>
</table>
CHAPTER NINE: ELECTROCONVULSIVE THERAPY

9.1 Both Scottish and English mental health legislation make provision for ECT in non-consenting (including incapacitated) detained patients, with certain safeguards: a second independent medical opinion is required.

9.2 The public perception of ECT is often negative and media coverage is usually of individuals, or their families, recounting traumatic experiences. This negative coverage can include covert and overt messages that no one should be given ECT against their will. It may even support campaigns for this position. It is implied that compulsory ECT is not only not helpful but may be positively harmful and traumatic (Wheeldon et al. 1999).

9.3 How far negative media representation of ECT lead to patients refusing it, or relatives objecting on their behalf, is not known. An example of the latter case is described in the section on nearest relative from paragraph 11.92.

9.4 A study in Aberdeen in the early 1990s looked at outcomes for patients consenting to ECT and those receiving ECT “involuntarily” (Wheeldon et al. 1999). Of 17 detained patients 6 gave informed consent to ECT. The other 11 refused ECT rather than being deemed incapable. Of 133 informal patients 83% found ECT helpful and 78% would have it again. Of the formal and consenting patients 83% found it helpful and 83% would have it again. Of the formal but non-consenting patients 82% found it helpful and 73% would have it again. Patients’ perceptions of the usefulness of ECT closely agreed with that of their clinicians. Of the total sample 37% could not remember how good or otherwise was the explanation of treatment and this might reflect short-term amnesiac effects of ECT.

9.5 The authors suggest that the publicity given to the negative outcomes of ECT is not representative and, because the number of detained patients in the study is small, a larger, independent study is necessary “to inform future debate”. The difficulties of defining who is to be considered incapable in relation to consenting to ECT is discussed in the section on voluntary patients from paragraph 10.29.

9.6 The New South Wales Mental Health Act 1983 did not allow ECT to be given without informed consent unless two medical practitioners, one of whom had to be a psychiatrist, agreed that it was “necessary immediately in order to save the life of the patient” (Durham, 1988a). This meant that patients who were willing to receive ECT but who were deemed incompetent were unable to be treated. For involuntary patients who did give consent the validity of this consent had to be confirmed by a magistrate at a special inquiry.

9.7 Leaving aside the problems of the definition of informed consent in the Act Durham pointed to the problems whereby, for example, a patient with delusional depression, who agrees to ECT, cannot be given it. This is because consent falls “short of being perfectly informed” and there was no provision in the law for proxy consent.

9.8 As Durham points out, this is in remarkable contrast to other interventions where proxy authorisation may be given. This includes psychosurgery for an incompetent patient if “the patient has not indicated any opposition to the psychosurgery”. Other surgical interventions such as sterilisation are also included. In this case the authorisation may be given for a capable but refusing patient.

9.9 Durham argues that the conditions of the Act in respect to ECT for incapable patients can never be met as ECT is highly unlikely ever to be, “the sole available life-saving measure ‘necessary immediately’”. He suggests that what is normally meant is that, “it is the safest
one, and the most practical and humane.” Other interventions, such as “intensive custodial care” cost more in terms of “great and prolonged suffering for the patient and, less importantly, of labour and money”.

9.10 In examining this anomaly, Durham dismisses “mere oversight” as the explanation and concludes that:

“there is and can be no rational basis for the anomaly, which surely has its origin in various kinds of ignorance and misconception” (Durham, 1988a).

9.11 The 1990 Mental Health Act in NSW still has strict guidelines for the use of ECT. For voluntary patients a Mental Health Tribunal is needed to grant consent to ECT unless there is an emergency, when consent can be granted by the Medical Superintendent (Singh, 1996).
CHAPTER TEN: VOLUNTARY PATIENTS

10.1 Informal or voluntary patients are admitted to hospital and receive treatment only with their consent. Intervention without consent constitutes battery in law unless the patient is incapable of giving consent. In many cases patients do not object and consent is taken as implied, or is assumed. Consent, even implied consent, has to be free from coercion to be valid.

10.2 It has been noted that voluntary patients have less right to information and no recourse to the safeguards provided by the Mental Health Act.

10.3 As noted elsewhere, many informal patients do not know of their right to leave hospital or refuse medication (Robinson, 1994; Sugarman and Moss, 1994). Since a “substantial number” believed that they would be coerced into staying in hospital or taking medication if they made any objection it was suggested that the rights of voluntary patients be included in any new mental health legislation (Robinson, 1994). As a minimum they should receive the equivalent information, both written and verbal, as a detained patient.

DETENTION OF VOLUNTARY PATIENTS

10.4 Patients may be right to fear coercion. Informal patients who try to discharge themselves may find themselves detained if they meet the criteria of continued hospital admission being urgently necessary by reason of mental disorder for their own health or safety or for the protection of others (section 25 (1) MHSA). If they cannot be detained, cannot be persuaded to stay and discharge is not recommended they will be discharged against medical advice (AMA).

10.5 A study in an inner city general hospital in Scotland looked at all patients discharging themselves AMA or detained under section 25 (1) between 1st January 1988 and 1st May 1991 (McGilp and Kidd, 1994). Of 2,010 discharges 66 (3%) were discharged AMA and 54 (2%) were detained.

10.6 Patients who were detained were significantly more likely to have been detained in the past, to be psychotic and to have deliberate self harm, threat of suicide or violence mentioned in the relevant case note entry. Patients discharged AMA were significantly more likely to have a previous history of or current diagnosis of substance abuse. Although only 15% of those discharged AMA had a current primary diagnosis of substance abuse 58% had a history. Of those detained, half had a history of dentition compared to 15% of those discharged AMA. Unlike other studies women were twice as likely as men to be seeking unplanned discharge in this study. The authors have no explanation for this. They conclude that current clinical state is the most important factor in determining the outcome request for unplanned discharge and the decision is not unduly influenced by the past. In this the doctors appear to be acting within the law in terms of current hospitalisation.

10.7 In England section 5(2) of the Mental Health Act 1983 allows for the detention of voluntary in-patients for up to 72 hours. There is no statutory right of appeal. If the RMO is not available a psychiatric nurse can detain a patient for up to 6 hours under nurses’ holding powers, section 5(4).

10.8 A study in North Cheshire over the period 1985-1995 found section 5(2) used in 4% of all admissions. Fifty per cent of these were converted to longer-term detention (Salib and Iparragirre, 1998). The rest returned to informal status. Section 5(2)s that were applied out-
of-hours, and probably by a junior doctor, were less likely to be converted to a longer-term detention. The authors conclude that the high rate of non-conversion suggests that “some applications were inappropriate” but the reasons given in case notes were poorly documented so this remains speculative.

10.9 A study in Essex for a one year period, 1992-1993, also looked at the issue of section 5(2) and also found it applied to 4% of admissions (Hall et al. 1995). In this study 57% of the patients detained were female, who were more likely to have an affective psychosis. Male patients were more likely to have schizophrenia or a paranoid state. Outcome of section 5(2) resulted in 51% being allowed to lapse, 7% being rescinded and 42% being transferred to either section 2 or section 3.

10.10 Five patients had been held on section 5(4); none were re-graded to a longer-term detention. There were 10 non-psychotic patients for whom section 5(20) was used and none were re-graded. Patients held by nursing staff were more likely to have a diagnosis of personality disorder or alcohol dependence.

10.11 Thirty eight per cent of all section 5(2) detentions took place within the first 24 hours and 5% within one hour of admission. These patients were more likely to have a psychotic disorder. This raises questions about the nature of their consent to be admitted.

10.12 The use of section 5(2) in a general hospital in-patient population was studied in two inner city teaching hospitals (Buller et al. 1996). During the five years 1990-1994 28 patients were detained, with case noted being found for 26. Sixty-three patients were detained out of hours. Of the total 77% were absconding, 38% showed evidence of a mental illness, 34% showed confusion and 34% showed suicidal ideation. In 88% of cases a psychiatric diagnosis was made at first contact. Fifty-four per cent were converted to a section 2 or 3.

10.13 The authors point to a number of problems with the implementation and follow up of the detention process and suggested that:

“a basic problem ...is the ignorance of doctors, both psychiatric and medical, of the appropriate parts of the Mental Health Act.” (Buller et al. 1996).

They suggest further guidelines are necessary.

VOLUNTARY ADMISSION OF INCAPABLE PATIENTS

10.14 In both Britain and elsewhere there has been concern over the hospitalisation and treatment of patients who lack capacity but who do not object (see also section on capacity from paragraph 12.1).

10.15 The American case which drew attention to this problem was that of Zinerman v. Burch in the US Supreme Court in 1990. Burch was voluntarily hospitalised in Florida while psychotic and believed that he was entering “heaven”. The court found that he had been deprived of his rights by being allowed to make an incompetent decision.

10.16 The American Psychiatric Association established a taskforce on consent to voluntary hospitalisation that reported in 1993. This recommended a low threshold be established for competence to consent to treatment.

10.17 In England the central judgement is that of the case of L in R. v. Bournewood Community and Mental Health Trust, ex parte L [1998] - Re L, usually referred to as the Bournewood judgement. In 1997 Mr L, who was autistic with severe learning disability was informally admitted to hospital following his becoming disturbed at his day centre. Although
he could not consent to the admission he did not object and so was not formally detained under the MHA. This was standard practice and followed the MHA Code of Practice (Department of Health & the Welsh Office 1993).

10.18 Mr L’s carers objected to the admission on his behalf. Had Mr L been a detained patient a close relative could make an application to a MHRT on his behalf and could also make a complaint to the Mental Health Act Commission. In the case of an incapacitated adult who is an informal patient the only recourse is to a judicial review. This is both costly and burdensome compared to the alternatives for detained patients.

10.19 Mr L’s carers took the case to court, which ended in the House of Lords over-ruling the Court of Appeal and upholding the common practice whereby an incapable but non-objecting adult can be informally admitted and treated by the common law justification of necessity (Crichton, 1998; Eastman and Peay, 1998).

10.20 Had the Lords not made this decision then many patients currently admitted informally would have required formal detention because of their inability to consent. This was of particular concern to psychiatrists in the sub-specialities of learning disability and old age psychiatry. Many had not detained patients to avoid stigma (Livingston et al. 1998; Mohan, 1998a; Singh, 1998). There was also concern about the additional resources required and it has been suggested that “worries about resources” guided the judgement more than anything else.

10.21 The Lords recognised the practical issues yet wanted to protect the rights of patients. The main grounds on which they overturned the Court of Appeal judgement was that the 1983 Mental Health Act was libertarian in concept and had not intended that anyone who was incapacitated should be automatically detained. Neither did it intend to withhold treatment from those willing to receive it.

10.22 Lord Steyne, in making his judgement, noted that their Lordship’s decision left incapacitated patients without the safeguards of the Mental Health Act and this was “an indefensible gap in our mental health law” (Crichton, 1998; Eastman and Peay, 1998; Hillery et al. 1999; Kearney and Treloar, 2000).

10.23 Some of these issues are being addressed in both England & Wales and Scotland in relation to the law on incapacity. The Mental Health Code of Practice has been updated to include the advice that the informal admission and treatment of mentally incapacitated adults is under the common law doctrine of incapacity (Dept of Health & Welsh Office 1999). Not all safeguards suggested are covered in the new legislation. For example, reviews of detention and treatment for such informally detained patients are still lacking.

10.24 Hillery, Tomkin and McAuley discuss the Bournewood judgement in relation to the law in the Republic of Ireland (Hillery et al. 1999). The different law there requires incapable patients to be detained under the Mental Treatment Act, wardship or by court order. Since generic psychiatric services do not usually treat people who are moderately or severely learning disabled and the Act does not apply to the facilities where they are treated it is not generally applicable. Wardship and court orders “tend to be thought too cumbersome to be appropriate”. This results in most adults with learning disability that are unable to consent being detained on a “best interest” basis. The authors report that, despite not having any legal force, proxy consent is usually sought from a relative or the doctor in charge of the residential facility where the patient lives.
Hillery et al suggest that a review system is needed involving independent, third-party inspection, one aspect of which should be “the obligatory detailing and reassessment of deprivation of liberty” and that this should be solely on the grounds of the patient’s best interest.

At the time of the Bournewood judgement it was estimated that if the Court of Appeal decision making informal admission of incapacitated patients unlawful had stood then there would have been an additional 22,000 people formally detained on any one day and a further 48,000 formal admissions per year. This was without including people in nursing homes which were not registered to admit detained patients but to whom the new interpretation of the Act might apply (Kearney and Treloar, 2000).

Kearney and Treloar carried out a survey in the former South-East Thames NHS Region of old-age psychiatrists. They found that although more than half the psychiatrists felt their practice had changed at the time of the Court of Appeal judgement this was not the case following the Lord’s judgement and only a minority now felt their practice to be affected (Kearney and Treloar, 2000).

Detentions rose slowly after the Court of Appeal judgement but there was no sign of a plateau by the time of the Lord’s ruling. The rate of detention appears to have returned to the pre Court of Appeal judgement levels. Of the old age psychiatrists who responded to the questionnaire, however, 73% agreed that the lack of safeguards was a problem.

That there is still confusion over treatment of incapable patients and to whom this label should be properly applied is illustrated by a query from Chubb and Alldrick. They report using the Mental Health Act to allow the use of ECT with patients incapacitated by mutism secondary to severe psychotic depression (Chubb and Aldrick, 2000). They surveyed colleagues in elderly mental illness and of the 20 out of 22 who replied all would do this. They point out that the Mental Health Act Manual suggests that ECT, as a medical treatment for a mental disorder, can be given under common law so long as the safeguards for treating incapacitated adults are followed. Chubb and Alldrick note that the new Code of Practice does not include mutism secondary to psychotic depression in its categories of those who might be mentally incapacitated, which only covers individuals with dementia, learning difficulty or with delirium.
CHAPTER ELEVEN: PATIENT’S RIGHTS

11.1 Although many of the rationales for patient’s rights are based on ethical principles that transcend particular legal frameworks the way these are argued might depend heavily on local law and tradition. The existence of the Bill of Rights in the United States has meant that much of its mental health legislation, as it relates to patient’s rights, has been dealt with as Constitutional matters. The Canadian Charter of Rights and Freedoms of 1982 has given advocates many similar arguments as those used in the USA to protect patients’ rights (Gratzer and Matas, 1994). This resulted in changes to mental health legislation in most provinces.

11.2 The adoption of the European Convention of Human Rights in Britain (May 1999 in Scotland, October 2000 in England) will presumably lead to challenges against mental health law using these rights in much the same way as happened in the United States. The Articles which are expected to be particularly relevant to mental health legislation include:

- Article 3 - the right not to be subjected to torture or inhumane or degrading treatment; where a treatment regime is particularly negligent
- Article 5 (1)(e) - the right of persons of ‘unsound mind’ not to be deprived of their liberty except in accordance with a procedure prescribed by law
- Article 5 (4) - the right of a detained person to take legal proceedings by which the lawfulness of his/her detention shall be decided speedily by a court
- Article 8 the right to respect for private and family life, home and correspondence if the nearest relative (who is involved in the detention) is fixed and unchangeable in law and the enforced medication of capable patients who refuse it
- Article 12 the right to marry and found a family
- Article 13 of Protocol 1 free elections by secret ballot under conditions which will ensure the free expression of the opinion of the people in the choice of the legislature (Hewitt, 1999).

11.3 Hewitt indicates that attempts to apply article 5 (1) (e) to in-patient treatment have so far failed, but also indicates that the environment must be therapeutic and not punitive. It may also be deemed unlawful to defer discharge until suitable accommodation can be found if this unreasonably delays discharge. This is particularly important given the ruling in England by the Lords that local authorities could take resources into account when deciding whether to fulfil their statutory duty to provide aftercare (Hewitt, 1999). The impact of Article 5 on MHRT is discussed in a dedicated section from paragraph 11.31.

11.4 Whether personality disorder is deemed a true mental disorder and the establishment of whether a person does or does not have such a disorder are expected to be subject to challenge, as is the recall of those with a so-called “civil” personality disorder who have not been convicted (Hewitt, 1999). MIND has also challenged the enforcement of Community Treatment Orders and suggests that where a person refuses to comply they would only be able to be detained if at that time, they could be shown to fulfil the criteria for detention (Hirst, 1999).
RIGHT TO TREATMENT OR SERVICES

11.5 The right to services or treatment “has never found definitive expression as a human right”, partly, at least, because of the difficulties in defining an absolute level, or standard, whether of treatment or resources, which is applicable across national boundaries (Gostin, 1985). It is possible, however, to argue that principles of equity and justice could be used within individual countries to argue for an entitlement to services as an enforceable right, rather than one based on chance, charity, professional discretion, geographical, class, culture or age discrimination.

11.6 The discussion around right to treatment falls into two main areas. These are the right of voluntary patients to treatment (including services in the community) and the more specific area of the right of patients to receive treatment (most commonly medication) when they refuse it, but it is deemed “in their best interest” by others and is usually argued under the parens patriae rationale. This includes when the person is deemed incapable or lacks insight.

11.7 The American Constitution has provided arguments both to support the right to treatment and to refuse treatment. Early challenges under the Fourteenth Amendment’s Equal Protection clause and the Eighth Amendment’s Cruel and Unusual Punishment clause were largely unsuccessful. However, the Fourteenth Amendment’s guarantee that no person could be deprived by the state of life, liberty or property without due process of the law did eventually bring about some change (Kapp, 1994). Arguing against the state’s parens patriae authority which enabled the state to protect those unable to protect themselves, the courts began to hold that if the state was to deprive a person of liberty then the state also had to provide treatment (see section on reciprocity from paragraph 2.61).

11.8 The Tenth Amendment had been used to involuntarily commit patients under civil law those people who were mentally ill and who also posed a danger to others. In 1975 the Supreme Court prohibited states from keeping non-dangerous patients involuntarily unless they were offered “more”, which presumably meant treatment (Gostin, 1985; Kapp, 1994). Article 3 of the European Convention has been used in Britain to compel minimum standards of care.

11.9 The right to treatment movement of the early 1970s grew out of concern over the conditions in which involuntary patients were kept and brought together some very disparate groups whose motivation sprang from radically different positions. Radical patients advocates were campaigning for a wide ranging right to treatment with the aim of pushing costs so high that states would decide to return patients to the community rather than be forced to pay such costs. The majority of right to treatment advocates, who included less radical patient groups, many mental health professionals, institutional administrators and labour unions however, looked for more funds to improve conditions for institutionalised patients and improve wages and conditions for staff.

11.10 The rights of involuntary patients who do not have medical insurance or private means to public community based mental health services has had a chequered career. Where the right to community based services exits it is largely as a result of state statute (Kapp, 1994). For patients with the means to buy private mental health services the right to treatment then becomes a matter of contract or tort law. It has been argued that if there were adequately funded and enforced right to treatment, which included the variety of services easily available and accessible to patients, then the desire to refuse treatment would be expressed less. This is since refusal can often stem from a rational awareness of current services and treatments and
patients are exercising their own costs-to-benefits analysis. There is also concern that refusal can stem from poor communication and a patient’s misunderstanding of the situation.

11.11 Whether legislation is the right approach to encourage better communication is debatable, but right to treatment does suggest that patients should have a good understanding of what is being offered. Barnes makes this point in response to Pereira et al’s suggested protocol for the enforcing of treatment by clozapine and the problems associated with the attendant need to monitor the patient’s blood (Barnes, 1999; Pereira and Beer, 1999).

11.12 Arguments against, or concerns about a right to, treatment are not necessarily the same arguments as those supporting the right to refuse treatment. Inevitably financial and resource concerns loom large. There were fears (as well as hopes) that increasing institutional costs would result in patients being returned to or ‘dumped in’ the community. It was generally thought that the setting and enforcement of treatment standards by the legal system would be disliked and distrusted. Also, that such standards could only deal with the structural aspects of care, such educational requirements and licensing of providers and that this could have little impact on an individual’s treatment and outcome. It was also argued that the right to receive treatment “lacked logical and practical congruity” with the right to refuse treatment (Kapp, 1994). This, however, need not be the case if the argument is about the right to services for those people who want them rather than enforcing treatment on those who do not want it.

11.13 The potential lack of congruity between the law and available resources to implement the law most appropriately is frequently noted. Indeed, it has been suggested that:

“passing a very forward looking mental health law- but doing no more is a very easy way for a state to claim to be aiming for the best care while spending no more than a fraction of what the best care would cost” (Zusman, 1985).

11.14 There is an assumption that people want to be well, i.e. sane and healthy, and that they have a right to this (Singh, 1996). It has been argued that the alternative to involuntary treatment is:

“usually not autonomy, but continued control of the person’s decisions by the illness with the resultant morbidity and mortality” (Gray and Keegan, 1999).

This has been one of the mainstays of the argument against the right to refuse treatment. Patients, it has been suggested, have “inner, unexpressed desires to get better so that they can once more exercise autonomy” (Kapp, 1994). Patients should be treated, it is argued, because their refusal is not “an accurate reflection of those patients’ consistent, authentic values and preferences” (Kapp, 1994). The main evidence given to support this are clinicians’ accounts of patients who have thanked them afterwards. This is taken to mean that the refusal of (usually) medication was illness based rather than rationally based, since patients then decided to institute a ‘living will’ (advance directive) allowing them to be treated in similar circumstances in the future (O’Reilly, 1998). The argument is thus that treatment is and should be a clinically based decision and not a legal one. This does not stop supporters of this position wanting the legal right to make this clinical decision and enforce it. Neither does it truly answer the question of what the patient would want at that point if they were able to make a rational decision.

11.15 Enforcing treatment is also supported by the argument that patients who refuse treatment are going to deteriorate and thus be involuntarily hospitalised. They will thus be in a more restrictive environment for a longer period of time. To support this Gray and Keegan
describe cases of patients who refused treatment and were subsequently detained for more than one year in Ontario, and contrasts this with other parts of Canada where treatment would be enforced (Gray and Keegan, 1999). This view has been encapsulated in the slogan that patients are able to “rot with their rights on” (Kapp, 1994). This argument is underpinned by the belief that psychotropic medication is safe and effective and that mental health professionals are motivated by beneficence. Clinical practice should thus lead the legal decision making process and not the other way around. Hidden behind these arguments can be detected a thread of anger and frustration on the part of mental health professionals who feel threatened by a legal intrusion into their professional autonomy. The paternalism of doctors shows through at this point.

11.16 Families are often at the forefront of arguing for ‘the right to treatment’, particularly for patients who are, or are likely to deteriorate without treatment, but who do not pose an overt danger to themselves or others (Dunham, 1985).

11.17 As Kapp points out with no large, multi-setting rigorously collected database (he is referring specifically to the USA but the point applies elsewhere) it is difficult to generalise about the impact of the law (Kapp, 1994). Where there is evidence it is generally anecdotal and impressionistic reflecting the experience of a single institution. Judicial decisions regarding the right to treatment have tended to defer heavily to the clinical opinion of the patient’s doctor and more recently have also been concerned, at least implicitly, with the resource implications, both financial and administrative.

11.18 Reviewing the situation in 1994 for the USA, Kapp notes the right to treatment, as meaning the right to community based mental health services, by people who currently cannot access them. This is either because of lack of finances (including lack of insurance) or lack of an ability to navigate the system and far outweighs the problems of enforcing medication compliance (Kapp, 1994).

11.19 McKay and Patrick cite the case of three pensioners who took Gloucester County Council to court following the local authority’s withdrawal of services provided under the Chronically Sick and Disabled Persons Act. The ruling was that the LA had acted unlawfully and could withdraw such services from individuals only if a formal re-assessment of their needs confirmed that they no longer required them, “shortage of resources is no defence”. The Scottish Office has affirmed that the formal needs assessment procedure “should be needs-led not resource-led” (McKay and Patrick, 1995).

RIGHT TO REFUSE TREATMENT

11.20 The discussion of a person’s right to refuse treatment obviously takes in the debate around incapacity and insight but includes whether patients who are detained still have the right to refuse treatment (most commonly medication). The right to refuse treatment can also be couched as the right to be left alone.

11.21 In the late 1970s and early 1980s there were several federal cases in the United States which broke new ground by successfully defending the right of the individual to refuse medication. Based on due process of law (or the protection of liberty) and using different parts of the American Constitution, successful arguments were based on freedom of thought and free exercise of religion, all promoting individual privacy and autonomy. The common law right of bodily integrity was used to further personal autonomy and also the doctrine of informed consent. The position was not, however, clear-cut, since one decision allowed for a “competent”, “non-dangerous” patient in a “non-emergency” situation to refuse treatment and
11.22 Following the doctrine of ‘least restrictive alternative’ refusal can be argued for meaning a different management programme, which might be just hospitalisation. Michigan gave a hierarchy of least restrictions as seclusion, physical restraint and then medication (Slovenko, 1989). Least restrictive alternative is an important point since a common objection to the right to refuse treatment seems to assume that commitment implies treatment, in which case to allow commitment but to also allow refusal “makes no sense”(Slovenko, 1989).

11.23 The patient’s right to refuse treatment has been generally accepted in the state institutional context but is not absolute and several things mitigate against it. Treatment can still be given based on valid state police power and parens patriae rationales and patients may find themselves subject to an involuntary hospitalisation when they may or may not be forced to accept medication. Where a patient does not meet criteria for forced medication the state has three options. It can detain the individual without treatment (warehousing), it can allow the person to return to the community without treatment, or it can wait for the person to deteriorate to the point where they enter the health system through the criminal justice system. Where the person does not meet the criteria for detention there seems to operate as ‘take it or leave it policy’. Patients who did not comply were expected to leave the institution.

11.24 The different states have a variety of models whereby treatment can be refused by involuntary patients involving the extent to which due process is required, who has the ultimate decision-making authority, how an emergency is defined and the authority of guardians to consent to psychiatric treatment (Kapp, 1994).

11.25 Appelbaum describes two categories of models, those which are rights driven and those which are treatment driven (Appelbaum and Roth, 1988). Rights-driven models determine the patient’s competency to make mental health care decisions through a process of court adjudication. Considerations of appropriateness or adequacy of medication or services is usually secondary. On the other hand, treatment-based models are more concerned with the appropriateness of the treatment plan for the patient’s presenting problems and are not really concerned with competency.

11.26 Kapp notes that in most instances where the case reaches court the model makes little difference (Kapp, 1994). Acting on a pragmatic basis, such as evidence of violence, patient’s objections are usually overruled and treatment is permitted. Where the patient’s incapacity to make a decision was one of the mandatory criteria used to detain the patient in the first place then it is accepted that no additional hearing is necessary and the psychiatrists decision cannot be challenged. It is acknowledged, however, that some incapable patients go untreated because they do not fulfil the dangerousness criteria for involuntary commitment.

11.27 A theme throughout the literature is that psychiatrists are inclined to label the majority of people who refuse medication, and who have a psychotic illness, as lacking insight, or are perceived as so doing. It therefore becomes very difficult for patients to legitimately refuse treatment and have this accepted. It is also commonly assumed that patients are coerced, covertly if not overtly, into accepting hospitalisation/treatment/ medication because of the threat hanging over them of the possibility of detention under the MHA.

11.28 If the right to refuse treatment were a legal decision then, as described above, mental health professionals have been concerned about their clinical autonomy. There has also been concern expressed about the resource costs of these procedures and the expected adversarial stance likely to be taken which is seen as anti-therapeutic(Kapp, 1994).
PATIENT’S KNOWLEDGE OF THEIR RIGHTS

11.28 This is also discussed in the section on detention in Scotland from paragraph 6.1. The question do patients know their rights? was estimated in a study by Eastwood and Pugh in the Norwich/Bury St. Edmunds/Cambridge area (Eastwood and Pugh, 1997). They looked at a group of voluntary patients, all on depot medication, 86% of whom were outpatients, 65% were male with a mean age of 44 years. They had good knowledge of their medication: 82% knew the name of the drug they were taking, 68% knew the correct dose, 95% knew the frequency of their injection and 82% knew when their next injection was due. Compared to this good information, only 52% were clear that they did have the right to refuse medication. One third of patients would have preferred oral rather than depot medication, but of these only half recognised they had a choice. Ten of the 14 involuntary inpatients thought that the depot was compulsory.

11.29 Is this lack of awareness a reflection of being a psychiatric patient? A study by Sugarman and Moss looked at patients in two large teaching hospitals and compared all involuntary psychiatric patients (including psychogeriatric patients) with all patients on medical and surgical wards (excluding paediatric and geriatric patients). Of 273 patients 207 were interviewed (Sugarman and Moss, 1994). Only 2 patients refused, the remaining patients were not interviewed because of apparent dementia or lowered levels of consciousness. The psychiatric patients were significantly younger. Psychiatric patients were more likely than medical/surgical patients to say that they did not need to be in hospital, that they did not need the treatment they were receiving and were more likely to say they would leave or refuse treatment.

11.30 There were, however, no significant differences between the groups on what they believed would happen if they wanted to leave or refused medication. If they wanted to leave only 52% of the medical/surgical patients and 44% of the psychiatric patients anticipated a non-coercive response. If they refused treatment 47% of the medical surgical patients and 44% of the psychiatric patients anticipated this response. Asked if they knew they had the right, by law, to leave or refuse treatment, only 51% medical/surgical patients and 44% psychiatric patients knew they could leave and only 38% medical/surgical patients and 39% psychiatric patients knew they could refuse treatment.

MENTAL HEALTH REVIEW TRIBUNALS

11.31 Mental health review tribunals consist of a lay person, a medical representative and a legal president. They are not a body who will retrospectively rule upon the validity of the original decision to detain a patient. In this regard, it has been noted, that they do not satisfy the European Court (Roberts, 1991). Mental health review tribunals first came into being in England and Wales with the Mental Health Act 1959. In discussing their purpose, the then Minister of Health, Walker Smith, stated:

“Just as the right of application to a tribunal is one of the main safeguards against improper admission under compulsory powers, so it is the main safeguard against unduly protracted detention”.

11.32 In some respects MHRT principles are in line with European Convention for the Protection of Human Rights and Fundamental Freedoms (1950), the Council of Europe Recommendations (1983) and the United Nations Principles (1991). These are that each decision to detain a patient or to extend his/her period of detention will be subject to independent, objective, judicial-type review. However, the Court of Appeal has upheld a
ruling by the Divisional Court that a MHRT was not a court within the meaning of the Article. It could not, therefore, act “as a primary decision-making body to cause the patient to be detained, but was simply there to review whether a patient’s detention was lawful” (Glover, 1996).

11.33 Delays of 8 weeks in arranging a MHRT in England have been ruled excessive (Hewitt, 1999). The burden of proof, Hewitt suggests, may move to those who seek to prolong detention and also need to show that the criteria for detention still apply although the patient may need to fulfil discharge criteria.

11.34 The MHRT model was proposed in the reform of the Mental Health Act in the Republic of Ireland and was broadly accepted by the Irish Division of the Royal College of Psychiatrists (Webb, 1997). The Irish Division of the Royal College of Psychiatrists, in its response to the White Paper, requested clarification that the scope of the proposed MHRTs examination of the validity of detention was confined to its continuance from the date of the hearing. Their concerns were that if a MHRT was to find that an original application for detention was invalid this may support legal actions against individuals or agencies instrumental in applying it (Webb, 1997).

11.35 Wood, while affirming the need for speedy redress to appeal for those newly diagnosed and detained under section 2 of the Act, has suggested extending the duration of the section 2 order for patients who have had previous relapses. This is in order to ensure full return of insight and thereby continued compliance with medication and he envisaged allowance of a later appeal to hearing time-scale for these patients (Wood, 1995). He has also, in a previous paper, suggested the procedure of an emergency review by the medical member only (Wood, 1993). Both suggestions have been criticised as running counter to the protection of civil liberties and the latter as being specifically in contravention of the European Court’s requirement for access to judicial appeal (Crimlisk and Phelan, 1999).

Factors influencing the decision-making process

11.36 A discussion of the legal safeguards for patients subject to detention under the Act focuses on the law as applied in MHRTs and argues that they tend to prefer the care and protection of patients, and that of others over concerns regarding a patient’s rights (Peay, 1986). Mental Health Review Tribunals are perceived by Peay as functioning in a quasi-therapeutic manner whereby they principally offer patients procedural safeguards but may not change their legal status. She indicates that the reasons that the legal criteria are subject to erosion in a therapeutic setting concern the membership, rationales and context of MHRTs.

11.37 A ruling to continue the detention of a particular patient illustrated these issues by description of the MHRTs decision-making process (Peay, 1986). The patient was appealing against his continued detention under section 3 of the Act having been, for some time, stabilised on and compliant with anti-psychotic medication, in employment and staying in hospital for only 4 nights a week. The patient affirmed that he was willing to continue with his medication therapy if discharged but the tribunal went on to consider the health and safety criteria. They took their decision not to discharge on the basis of the patient’s lack of insight into his illness and his likelihood of not continuing to take his medication when in the community based on previous patterns of behaviour. The psychiatrist’s submission that the patient had become violent on occasions of relapse was pivotal to this further discussion.

11.38 The preferred selection of judicial members with experience of criminal courts, Peay argues, places an emphasis on aspects of public safety and reasons for decisions are often
based on the therapeutic interests of the patient and the avoidance of causing harm to
themselves or others (Peay, 1986). The decision that a patient may cause or be subject to
harm may be tested no more rigorously than by the presentation of evidence of previous
behaviour and this may err on the side of caution to the detriment of the patient’s rights.

11.39 Richardson and Machin noted that the role of the medical member, both as witness and
decision-maker, is problematical (Richardson and Machin, 2000). Rule II of the MHRT Rules
requires that the medical member examines the patient prior to the hearing and is then required
to present the “likely issues” at the preliminary discussion and for consideration at the hearing.
This specifically excludes the presentation of the medical member’s clinical opinion (which
undoubtedly they will have formed) and thus offer a potential dilemma to this member in
resolving their duties to a patient as a doctor and their responsibility to the tribunal as a legal
decision-maker. The medical member is, “effectively a witness and a member of the tribunal
deciding the validity of his own evidence” (Council on Tribunals, 1983).

11.40 In examining this issue Richardson and Machin’s study observed 50 tribunal hearings,
collected data at their preliminary meetings, the oral hearings and the post-hearing
deliberations and conducted 37 telephone interviews with patient representatives, tribunal
members and office personnel. The results of the interviews and the observational detail
collected concurred in concluding that medical members were not asked at the preliminaries to
give their clinical opinion on the patient. Nevertheless, 50% of them did give their opinion of
the patient’s mental state and 50% also commented on prognosis at this stage of the
proceedings.

11.41 The oral hearing observations found no instances of medical members expressing their
clinical opinions directly but instances of medical members referring the patient to the dialogue
of the assessment interview in an attempt to replicate the evidence for their opinions did occur.
Most of the interviews with representatives described themselves as reliant on their perception
of the medical members’ direction of questioning in order to deduce their view. The dilemma
with this, explicitly noted by one interviewee, is that when the medical members view is not
clearly stated the principle that patients should hear their evidence, and that their
representatives should have the opportunity to examine it, is undermined.

11.42 The observational data revealed that during the post-hearing deliberations in 28% of
the cases medical members gave an opinion of the medical evidence, in 30% they gave an
opinion of mental state and in 58% of the cases the medical member offered an opinion on
prognosis.

11.43 The evidence of this study should be treated with caution since it is based on a small
sample and was dependent on tribunal members’ and patients’ agreement. However, it does
present a challenge to the requirements of procedural fairness in that clear instances are given
of medical members’ offering opinions outwith the oral hearing that are not explicitly
expressed in the company of the patient or their representative (Richardson and Machin,
2000). Given that this opinion is in some measure based on the pre-hearing assessment
interview with the medical member it may be seen as anomalous that patients are not
represented at this stage also.

Availability of resources

11.44 Shortages of appropriate resources are a prevalent concern in the mental health care
context and can lead to a pragmatic decision to continue detention despite a lack of legal
criteria (Peay, 1986). Wood also sees this factor as important in balancing freedom and
control. It is illustrated by the lack of speed and ease with which a patient can expect to move to an appropriate protective environment when becoming unwell or on to a less restrictive setting when stabilised (Wood, 1995). Roberts also affirmed the tensions between statutory criteria and availability of resources. He states the view that MHRTs make decisions that do not principally feature the statutory criteria preferring to base their decision on “common sense factors” (Roberts, 1991).

Characteristics of patients appealing to MHRTs

11.45 The proportion of patients appealing against their detention in the studies examined ranged between 13% - 27% for section 2 and 11% - 21% for section 3 (Saad and Sashidharan, 1992; McKenzie and Waddington, 1994; Bradley et al. 1995)

11.46 Bradley et al analysed information from the casenotes of 384 patients detained under section 2 in five districts in the Oxfordshire Regional Health authority to compare the characteristics of the 104 (27%) patients who did exercise their right to appeal with those who did not (Bradley et al. 1995). This revealed that patients who were better educated or who had been admitted previously were more likely to make an appeal while those who had a diagnosis of depression or dementia were considerably less likely to appeal. Having an education to A-level standard approximately doubled the likelihood of appealing against detention in this study sample.

11.47 Appeals to MHRTs under section 2 must be made within 14 days of detention and Bradley et al also interviewed 40 patients on the penultimate day of this period. Of the 28 (70%) patients who had not made an appeal 16 (57%) were unaware of their right to do so. Patients who did not appeal expressed greater difficulty in understanding the booklet about their rights. The need to write a letter, either because of literacy problems or the act of obtaining writing materials, was perceived as a deterrent to appealing. Patients were given a full explanation of their rights of appeal during the interview and 12 (43%) of those who had not appealed said that they would then like to. Four of them did so by the next day deadline and one was discharged as a result (Bradley et al. 1995).

11.48 Familiarity with their rights, either through ability to comprehend the information given, having been given the information in a comprehensible manner or having more experience “within the system” would appear to be the greatest influencing factors in encouraging patients to exercise their rights of appeal against continued detention. However, the MWC study into patient’s knowledge of their rights found highly significant deficiencies but, since the population included patients on their visiting programme, a high proportion of them would have been detained for longer than 2 years. These issues are further discussed and broadly supported by studies on issues of patients’ rights in Scotland from paragraph 6.1.

Outcomes of MHRTs

11.49 The belief that most MHRTs uphold psychiatrists’ decisions to continue detention has been clearly stated (Peay, 1986). However, it is been acknowledged that there is a wide variation between Tribunal Regions’ discharge rates (Roberts, 1991). Empirical studies in different areas of England indicate that the percentage of patients discharged as a result of their hearing’s decision varies enormously. By examples, a study based in a Middlesborough hospital reported only 9% of appeals resulting in discharge (Milne and Milne, 1995) 17% in Oxford (Wilkinson and Sharpe, 1993) and 19% in Bradford (McKenzie and Waddington, 1994). These were considerably less than the 33% discharged by tribunals over a study period
in London (Ismail and Smith, 1998) another in Shrewsbury which reported 34% (Myers, 1997) and in Birmingham which found 50% discharges at MHRTs (Saad and Sashidharan, 1992).

11.50 No clearly discernible reasons for the variation in the rates of discharge between different studies were apparent. The Shrewsbury study examined a high proportion of patients who were appealing against section 2 detentions (80 patients 73%) and 40% of them were discharged compared to 23% of the 30 patients who were appealing against section 3 detention (Myers, 1997). Blumenthal and Wessely investigated the pattern of delay in MHRTs for 150 patients detained under section 3 and reported no correlation between delay and outcome but did find that significantly more patients who were represented were discharged by the MHRT (Blumenthal and Wessely, 1994).

11.51 The outcomes of the 110 patients who were admitted to the hospital in Shrewsbury studied patients whose detentions were reviewed by a MHRT between 1st October 1983 and 31st December 1991 (Myers, 1997). All patients were followed up until 31st May 1993 and the study only considered the first or only hearing and outcomes. Factors considered in the follow up period were subsequent instances of harm to self or others and comparison between those who were discharged by the MHRT and those who were not. This last was regarding the length of time that survival in the community was sustained, circumstances at follow up point and readmission rates.

11.52 There were no significant associations between tribunal decisions and outcomes. Myers noted that patients discharged by the MHRT were not prematurely readmitted and this may be thought to uphold their decision. However, it could not be ruled out that this decision to discharge may have caused GPs or psychiatrists to be more circumspect in readmitting in the absence of a radical change in clinical features (Myers, 1997).

Appeal hearing delays

11.53 Several studies raised concerns about delays in processing appeals to MHRTs. Excessive delay contravenes article 5 (4) of the European Court ruling and it is the stated aim of MHRTs to guard against unduly protracted detention (Milne and Milne, 1995). There is a statutory duty to set a hearing date for no later than 7 days after an application is received from a patient detained under section 2. Although there is no statutorily defined time limit for section 3 and Part III appeals, targets for time between appeal and hearing have been set at 8 weeks for unrestricted and 12 weeks for restricted patients (Pudlo, 1987). In all the literature reviewed instances of delays far in excess of these targets were documented. Delays of 8 weeks have been ruled excessive (Hewitt, 1999).

11.54 Milne and Milne reviewed the 169 appeals in made by (or on behalf of) patients in a hospital in Middlesbrough during 1988-92. They concluded that the 49 (29%) section 2 appeals were dealt with “promptly” (Milne and Milne, 1995). However, although the mean was 6.8 days, some patients’ appeals fell outside of the seven-day requirement under section 2 since the range was between 6-20 days between appeal and hearing date. McKenzie and Waddington found a median of 6 days with a range of 3-8 days for appeals against section 2 (McKenzie and Waddington, 1994). However, this only looked at 12 such cases. Blumenthal and Wessley examined 221 MHRT appeals and excluded those for patients under section 2 because “there are no problems with delays in these cases”. However they did comment that section 2 appeals had increased dramatically and are often not convened due to discharge prior
to appeal date thus placing a wasted administrative burden on MHRT that may be at the
expense of expediting appeals that are heard (Blumenthal and Wessely, 1994).

11.55 Seventy-seven patients detained under section 3 had to wait an average of 3 months
between appeal and hearing date with some patients waiting for as much as 6 months
(Milne and Milne, 1995). Although there was some correlation between the submission of social
work reports (but none in the case of medical reports) and delays, the main factor contributing
to delay was the time taken between receipt of reports and hearing date. This indicated that
the main source of delay was the MHRT office. Blumenthal and Wessley found that the more
reports that a social worker had to prepare in a month the greater the delay (Blumenthal and
Wessely, 1994). Delays between receipt of report and hearing date may, in some cases,
undermine the validity of the report.

11.56 Milne and Milne found that restricted patients detained under Part III had to wait
significantly longer for their appeals than those on section 3. Most had to wait 6 months with
some cases being delayed for up to 9 months. Reasons that may contribute to this were noted
(Milne and Milne, 1995). A legal member of greater seniority is required and may be less
readily available, and the Home Secretary is required to provide a statement within 3 weeks of
receiving the medical and social work reports. Blumenthal and Wessley found no correlation
between Home Office reports and delays for restricted patients. Their 115 restricted patients’
appeals did take an average of two and a half times longer than those for the 106 unrestricted
patients studied, this being considerably more than the one and a half times target set by Pudlo
(Pudlo, 1987; Blumenthal and Wessely, 1994).

11.57 Lack of judges’ time was noted as a frequent complaint from clerks in MHRT offices.
The rise in the number of patients appearing with representation over time (82% in this study)
was believed to contribute to increases in delay overall. Patient’s representatives had in all
cases requested independent psychiatric reports (IPR) and the time to this report correlated
significantly with the time to hearing. Requests for IPRs also resulted in a number of
adjournments. Milne and Milne noted that the excessive delay for Part III patients was
particularly regrettable given their findings that significantly more of these patients were
discharged.

11.58 McKenzie and Waddington also found excessive delays in appeals for 44 patients
detained under section 3 (McKenzie and Waddington, 1994). The average time between
appeal and hearing was 7 weeks with a range between 3 and 16 weeks. The high rate of
discharge by the RMO prior to the appeal date (17 patients 39%) was postulated as a factor in
this.

**DECISION MAKING BY PROXY**

11.59 If a patient is unable to consent then in some circumstances the nearest relative is able
to be a formal part of the decision making process (see the section on family from paragraph
11.89). The nearest relative can be ‘displaced’ and in that case the court can take on the
powers of the nearest relative. The circumstances that would allow this are that:

the patient has no nearest relative
it is not ‘reasonably practicable’ to trace such a relative
the nearest relative is also incapable
the nearest relative unreasonably objects to the application
the nearest relative discharges the patient without due regard to the patient’s
welfare or the public interest.
11.65 Various solutions to proxy decision making have been suggested. These include advance directives, continuing powers of attorney, second opinions for specified or controversial treatments, court appointed managers for some procedures or situations, a judicial role for both appeals and treating patients who refuse/object to treatment.

11.66 The latter could also be used with incapable but non-resisting patients (Szmukler and Holloway, 1998).

11.67 When making a decision for another person the debate is around whether this should be based on best interests or substituted judgements (Wong and Clare, 1999). Best interest is based on the principle of beneficence and can be argued to be paternalistic. It is usually seen as being based on necessity or emergency (e.g. life threatening situations). The issue is not so clear, however, when the situation is neither an emergency nor ‘necessary’ in the sense of maintaining life, but may be necessary to improving the quality of the person’s life by treating the illness. In such circumstances it has been suggested that best interest should be seen as a much broader concept, taking in the previously expressed wishes of the individual, the views of significant others and ‘least restrictive’ action (Wong and Clare, 1999). Such an approach clearly includes aspects of substituted judgement. It does not, however, clearly identify how potential conflicts of interest should be identified or resolved.

11.68 There is some evidence that potential proxies are poor predictors of health care decisions. Few countries have moved to a hierarchy of proxy decision making, although Australia has done so (Wong and Clare, 1999). Substituted judgements should reflect the views of the individual and represent that person’s choice if they had capacity. One way of ensuring this might be through advance directives (see the next section). Substituted judgements are usually taken as the central tenant of advocacy.

ADVANCE DIRECTIVES

11.69 Many writers make passing reference to the potential usefulness of advance directives without ever clearly specifying what they mean by the term (Hoffman and Srinivasan, 1992; Eastman, 1994; Appelbaum and Grisso, 1995; Stefan, 1996; Fulford and Sayce, 1998; Szmukler and Holloway, 1998; Thomas and Bracken, 1999) This section is not a review of all the literature on advance directives but only those found within the search as outlined earlier. Generally, most literature on advance directives is in relation to end-of-life situations and is reflected in terms such as “living wills” and “advance refusals of treatment”. There is very little of substance on advance directives in relation to mental illness.

11.70 At present advance refusals of treatment are legally binding in common law if they have been made by a person who was capable at the time of making the decision and if they are only used in the circumstances for which they are intended. This is usually taken to mean the ‘do not resuscitate order’. They are generally not seen to apply in mental illness since the Mental Health Act can overturn an individual’s request not to be treated. The status of other forms of advance health care statements is less clear (Wong and Clare, 1999).

11.71 In the United States advance directives are more common since the implementation of the Patient Self Determination Act 1991 (Pellegrino, 1992).
In psychiatry the concern is as likely to be with patients consenting ahead to treatment as with refusals. Indeed, Mester et al describe such possibilities as “anticipatory consent for psychiatric treatment”, “consent-in-advance” or “prior agreement to further involuntary treatment” (Mester and Toren, 1994). They suggested that it “would be hard to refute such a decision if it were based on sound understanding” and suggested that:

“advance consent is intrinsically a less problematic issue, from the ethical view, than the decision to stop vital life-maintaining therapy as is usually the case in living wills” (Mester and Toren, 1994).

They reported the small-scale use of a “preventative hospitalisation agreement” in Israel. In this the staff and the patient agreed that the patient would voluntarily enter hospital for a week of intensive care before the predicted time of the next relapse. This was a voluntary hospitalisation but they did not explain what is meant by “predicted psychotic relapse”, how this is measured and who instigates the process.

Safeguards around advanced consent have been suggested (Rosenson and Kasten, 1991). These include:

- previous good response to medication
- previous relapse of behavioural as well as symptomatic deterioration of at least 2-3 weeks
- the involvement of the same therapist as managed the previous relapse
- third part involvement and a hearing by either an independent medical or judicial review before the advance consent is enacted.

It has been suggested that safeguards at this level would make advance consent almost impossible to implement.

Rogers and Centifanti objected to these proposals as being “all-or-nothing”. They suggested a form of medical directive that lists types of interventions a patient would accept or reject, now and in the future (Rogers and Centifanti, 1991). One problem with this is that the patient is unable to choose to accept or reject a particular intervention without knowing the reasons why it is being proposed and whether those reasons reflect their values and interests (Brett, 1991).

Some patient groups, notably the Manic-Depression Fellowship, have supported the issue of advance directives and some have advocated the use of crisis cards, which could also be seen to fulfil some of the functions of an advance directive. Crisis cards, drafted while a person is well, are informal but can be seen as an important aid to self-advocacy.

Psychiatric advance directives raise a number of issues, even without their potentially complicated relationship with any mental health legislation. Any advance directive has to be drafted while the person is clinically well and has capacity (Wong and Clare, 1999). This raises all the difficulties discussed in the section on capacity as to how patients who deny their illness or generally refuse treatment are to be designated. Clearly, using this model, advance directives will never be appropriate for someone who will never develop capacity. This is not to say that that individual’s views and opinions should not be listened to and respected as far as possible; this is probably best achieved through advocacy.

Neither does this address the philosophical question of the relationship of the competent person to the incompetent individual and the relative rights of each.

Advance directives also require the individual to anticipate the circumstances in which the statement will come into force. Paradoxically, this might be an area of strength for people
who have a severe and enduring mental illness with recurrent acute episodes. Such individuals are probably amongst the best placed to appreciate the situation in which advance directives might be used and the ways in which it might be important. There is, however, research which calls into question patients with schizophrenia’s ability to recognise the need for treatment both in the present and the future (Appelbaum and Grisso, 1995).

11.81 There is also the issue of new and unanticipated treatment options becoming available that a previously refusing patient may accept.

11.82 A particularly important issue may be economic. A patient may want to refuse medication but may agree to the very much more expensive option of hospitalisation. If medication might have kept the person out of hospital, or reduced their stay, the resource implications could be considerable.

ADVOCACY

11.83 McKay and Patrick have outlined the status and role of advocacy in a chapter within *The Care Maze* and affirm that:

> although advocates do not normally have a general legal status, there are various procedures which give specific rights to advocates” (McKay and Patrick, 1995).

A patient can insist on having a “patient supporter” with them when in discussion with the NHS over their care and treatment in matters such as assisting them in decision making and dealing with complaints. People with learning disabilities and mental illness should have an independent “appropriate adult” present in all interviews with the police.

11.84 The role of advocacy, it has been argued, has been central in the history of user/survivor movements in the UK. In the context of mental health, advocacy owes its inspiration to the “anti-psychiatry” theses of Laing, Szaz and Cooper (Campbell, 1996). Thomas and Bracken highlight its current-day role as being within the boundaries of the prevailing forces of consumerism which have extended into all areas of health care in the UK (Thomas and Bracken, 1999). This impetus has resulted in a plethora of government papers such as The Patients Charter and Local Voices: the Views of People in Purchasing for Health (NHS Management Executive 1992). Thomas and Bracken implicitly expound the case for crediting equal cognisance on the rights of those that subscribe to mental health services as to all other health service consumers when they argue that:

> “The use and misuse of medical power, whether in paediatric cardiology or psychiatry, requires a very clear response…advocacy has a key role to play in mediating the dangers of unchecked medical paternalism in psychiatry” (Thomas and Bracken, 1999).

11.85 Campbell argues that professionals apply the term “anti-psychiatry whenever their professional judgement is brought into question” (Campbell, 1996). Whilst not dismissing the movement’s antecedents, Thomas and Bracken argue that advocacy’s relationship to anti psychiatry “is more spiritual than practical”. However, in a response to this article Graham is more supportive of the anti-psychiatry movement. While he acknowledges that it caused a “great deal of harm” to people with psychotic illnesses and their families he argues that:

> “[the anti-psychiatry movement] resulted in bringing home to psychiatrists the need to listen with greater attention to people with ‘crazy’ ideas and…”
ultimately lead to better collaboration between professionals and those caring for patients at home” (Graham, 1999).

11.86 In the context of all medical health care professionals, psychiatrists are perceived as being especially resistant to the voice of their consumers and their representatives. Literature on advocacy is particularly scarce in psychiatric sources. Thomas and Bracken applauded the report for the Royal College of Psychiatrists’ Public Policy Committee, but they saw its reception by, and its status within the College as being an area for concern (Royal College of Psychiatrists, 1989). They recommend that psychiatrist be exposed to advocacy during their training and suggest the inclusion of a section on advocacy in the logbook system for trainee psychiatrists (Thomas and Bracken, 1999).

11.87 The UK Advocacy Network (UKAN) is a federation of patients’ councils, advocacy projects and user forums for mental health service users. In their recently produced code of practice they identified the various types of advocacy (UKAN and the NHS Executive, 1997). Self advocacy was held to be the ideal model so that achieving the greatest proximity to this may be seen as the main objective. However, various factors can impede the realisation of this or demand that other considerations take priority over it for some users and/or under some circumstances. Discussion that relates to this can be found in the other sections in this review but particularly the chapter on competency. The kinds of advocacy that have the most impact on psychiatry are self-advocacy, peer advocacy and volunteer advocacy.

11.88 Peer advocacy takes the form of a group of informed individuals who have personal experience of mental illness and support those others in a range of concerns regarding service delivery. They are often organised by an independent service based in appropriate local settings such as a community mental health resource centre. Peer advocacy would aim to involve the person being advocated for as intimately as possible in the process. The main distinction between this form of advocacy and volunteer advocacy may be the degree to which this is facilitated. An example of a volunteer advocacy service is that which is currently operating in Carstairs State Hospital. A qualified individual (paid by the hospital) who organises advocacy for their patients through the use of trained volunteers runs this service. In this instance matters of security and confidentiality take precedence over the active involvement of the users at a group level. Self-advocacy is the model most discussed within psychiatric literature.

FAMILY AND MENTAL HEALTH LAW

11.89 There is very little that considers the role of the family in relation to mental health law or the impact of the law on the family. Since the Mental Health Act 1959 (1960 in Scotland) which first gave emphasis for patients to be treated in the community and near to their families there has been a growing literature on the impact of caring for a relative with a severe mental illness on the family. Any legislation which enables severely ill people to remain in the community will have a direct and indirect impact on the patient’s family.

11.90 The second main area where the family have an involvement is in the detention procedure itself. Although views are sometimes expressed that it can damage the relationship between family members to have one commit or sign in another there is no real research in this area.

Nearest relative
11.91 The nearest relative can object to their ill relative’s detention but the court can overturn this. Again, there is no real research on why or how often this occurs, or what the impact on continued support for the patient is when it does occur.

11.92 Shah described a case history of a woman in her 70s with depression who was considered unable to consent to ECT. Two psychiatric recommendations for a section 3 were completed, but since the patient’s husband objected the social worker was unable to complete the section 3. Social services later took the case to court to displace the nearest relative and 2 weeks after the initial medical recommendation the patient began ECT and recovered, enabling her to be discharged home (Shah, 1996).

11.93 Shah raised a number of practical and ethical issues from this case. The couple had been married for nearly 50 years and it was thought that the involvement of the court would be unlikely to effect a relationship of this length of time. The patient was, however, aware of the legal battle and there was concern that the stress arising from the uncertainty of the outcome and her loyalty to her husband might have perpetuated her depression. It was hoped that this was minimised with staff support.

11.94 The husband objected to ECT and “suggested unreasonable and inappropriate treatment for severe depression; i.e. counselling and relaxation”. Given the amount of negative media coverage of ECT it might be that special consideration needs to be taken in involving relatives in consenting to, or refusing, ECT (see also the section on ECT from paragraph 9.1).

11.95 Shah also raises the interesting issue of the financial implications of the spouse’s “unreasonable behaviour” since he did not receive legal aid and they shared assets. Is this an area where a patient’s finances need protecting?

11.96 Finally Shah queries why, when the Mental Health Act already has the safeguard of a second opinion before ECT is given to detained patients the judge overlooked this, granting a delay in the proceedings for the husband to obtain a third opinion. This was not produced in court, leading to the “obvious assumption...that the independent medical examination was unfavourable” to the husband’s case. This raises the question of how much credence is given, by both relatives and the court, to the independent second opinion.

11.97 Relatives can rescind their responsibilities as nearest relative. Cooke at al give an example of a father who rescinded in favour of his ex-wife who was much more involved in their son’s care (Cooke et al. 1994). The case was then complicated by the psychiatrists seeking to displace the mother as the nearest relative. The authors raise the issue of the difficulty in defining what is an unreasonable objection on the part of the relative. In this case the mother did not accept that her son had a mental illness and believed that medication was harmful and addictive.

11.98 They review other cases where the nearest relative, although accepting the need for treatment, did not believe this needed to be in hospital. They give the ruling of a 1974 case in the Court of Appeal (W. v. L. (1974) Q.B. 711) which viewed as more important how a (hypothetical) objectively reasonable relative would act in the situation than the patient’s wife, whose view was what was subjectively reasonable.

11.99 This would seem to beg the question of whether the nearest relative can, or is likely ever to be anything other than subjective in their response to their relative’s situation. It may be that the nearest relative is taking an over-optimistic view and/or willing to take what others
consider to be unreasonable risks. In this case, the court concluded that the risk to the patient’s wife’s unborn child was too high for him to be treated at home.

**Family burden**

11.100 Although there is research on the “burden” of caring for someone with a severe mental illness and the services relatives want this has not be related to involvement in instigating detention. Slovenko suggests that professionals are more likely to see harm to self or others as warranting outside intervention than non-intentional harm and implies this is more likely to be brought as an issue by the family (Slovenko, 1989).

11.101 Taiwan involves the relatives directly in the care of patients through the law. Not only does the law require family members to assist the patient in seeking treatment but also it holds them responsible for damage to others caused by the patient should the “guardians” fail to perform this duty. This is clearly controversial since it ignores the ability or adequacy of family members to act as a legal caretaker for the patient. It also raises questions as to whether the family should be legally obliged to care for their ill relative, particularly with no clear duty to protect the family’s rights and welfare (Salzberg, 1992; Yeh, 1998). This is also discussed in the section on the hogosha system in Japan under guardianship from paragraph 5.18.

11.102 Needs assessments for community care should take the carers needs equally into account. Under the Chronically Sick and Disabled Persons Act the person conducting the needs assessment must bear in mind whether the carer is able to continue to care for a person on a regular basis. Taking this into account may give a carer the legal entitlement to some services such as respite care (McKay and Patrick, 1995).

11.103 Carer’s organisation’s, notably the National Schizophrenia Fellowship (NSF) and National Schizophrenia Fellowship (Scotland) represent carers views, although they are unlikely to be fully representative. Some limited support has been given to community measures, although the message is not always clear. Thus the NSF did not support community supervision orders, although they did support supervised discharge (Silberston, 1994).
CHAPTER TWELVE: CAPACITY, COMPETENCY AND CONSENT

12.1 This section only deals with the issue of competency briefly and a full literature search was not conducted on this. The comments made are in relation to people with a mental illness only although it is noted that with the increase in prevalence of dementia it can be assumed that there will be more issues concerning capacity with this group (Wong and Clare, 1999). Also, with more people with learning disability and mental illness living outside hospital they have more opportunity for decision making and thus increase the number of situations in which their capacity might be questioned.

12.2 In various places and at various times the capacity of people with a mental illness to consent to treatment and hospitalisation, to manage property, to enter into contracts, to make a will, to marry or to vote has been questioned (Winick, 1995). The capacity of an individual to stand trial under criminal law will not be considered in this section. Neither will this section consider the stigmatising effect of being labelled incompetent nor the deleterious psychological consequences. These negative outcomes have, however, lead to the suggestion that incompetency should be narrowly defined (Winick, 1995).

12.3 It is also noted that competency is rarely questioned when a patient consents to treatment (Hoffman and Srinivasan, 1992).

12.4 A point frequently made about the 1983/1984 MHAs, are that they allows a competent adult to be treated against their will for a mental disorder whereas there is no equivalent law which allows a competent adult to be treated for a physical (or bodily) disorder (Fulford and Sayce, 1998; Szmukler and Holloway, 1998). People can be detained and examined for certain communicable diseases, but not treated against their will. This leads to the question whether mental and physical disorders should be treated the same.

DEFINITIONS OF CAPACITY OR COMPETENCY

12.5 The search for a single, operational standard of competency has been described as “a search for the holy grail” (Roth et al. 1977). The first question is whether a legal or clinical definition of capacity is appropriate. Winick, a lawyer, argues that:

“recognising that competency is more a legal than a clinical question allows greater flexibility in defining the concept” (Winick, 1995).

He bases this on the range of subjective cultural, social, political and legal judgements that make up a normative decision of competency.

12.6 The Butler Committee (Home Office and Department of Health and Social Security, 1975) indicated that only severe mental disorder should be regarded as incapacitating in the relevant legal sense. The committee defined ‘severe’ operationally through a list of specific cognitive and psychotic symptoms. Fulford and Hope suggest that this is broadly consistent with practice, although it is not specified in this way in the Mental Health Act (Fulford and Hope, 1993)

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1 Terminology becomes difficult here as making a distinction between ‘mental’ and ‘physical’ suggests a Cartesian mind-body dualism that may or may not be appropriate. To some such terms may suggest that mental diseases do not have a physical cause. There is not the space here to debate these issues.
12.7 The Law Commission report on incapacity (1995) suggested a “workable” definition of incapacity for physical disorders, but mental disorder was excluded. One concern in adopting the Law Commission’s definition of capacity in mental illness is that it is based on understanding rather than wisdom. The Mental Health Act is concerned with decisions made by a person which are deemed not wise. Eastman and Peay concluded that to define capacity in mental illness more research was needed (Eastman and Peay, 1998).

12.8 A report by the American Psychological Association in 1993 established a low threshold for capacity to consent to hospitalisation (Draper and Dawson, 1990). Capacities were limited to being able to communicate a choice and to understand the relevant information.

12.9 The Mental Health Act of Ontario 1987 requires a patient to be able to understand the nature of the illness for which treatment is proposed, understand the nature of the treatment and be able to appreciate the consequences of either giving or withdrawing consent to be deemed competent (Hoffman and Srinivasan, 1992).

12.10 Different states in the USA have different rules about competency. By the mid-1990s 14 States had defined capacity. There are 8 different conditions, used by a variable number of states:

- understand relevant facts (8 states)
- understand or weigh risks and benefits or treatment and any alternatives (6)
- communicate a decision (5)
- appreciate one’s illness or nature of the decision (4)
- use rational thought process (3)
- make wilful or voluntary, knowing and intelligent decision (2)
- can make rational decision (1)
- are able to articulate reasonable objections (1).

Alaska has the most conditions (understand relevant facts, appreciate one’s illness or the nature of the decision, use rational thought process and be able to articulate reasonable objections). Arizona and Wisconsin (understand or weigh risks and benefits of treatment), Colorado (communicate a decision) and South Dakota (make full or voluntary, knowing and intelligent decision) all have one.

12.11 In defining capacity there is a balance to be struck between the right to freedom of decision making and a right to protection from harm although there is some agreement that the threshold for capacity should be low (Winick, 1995). This is further discussed in sections on voluntary patients (from paragraph 10.1), the right to refuse treatment (from paragraph 11.20) and the right to treatment (from paragraph 11.5). Adults are presumed to have capacity until proved otherwise. Whether tests of capacity presume this and seek to measure lack of capacity or whether they seek to determine capacity is a moot point. Whatever else they do, tests of capacity seek to establish a threshold.

12.12 The legal concept of capacity, however, seeks a concrete decision, the person is or is not competent, which can be seen as both artificial and ambiguous (Winick, 1995).

12.13 Winick, an American lawyer, argues that the negative consequences of being labelled incompetent are:

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2 These States were: Alaska, Arizona, California, Colorado, District of Columbia, Florida, Hawaii, Idaho, Kansas, New York, Maine, South Dakota, Texas and Wisconsin.
It is yet to be seen whether such arguments are made in relation to the European Convention of Human Rights.

DETERMINING CAPACITY

12.14 One difficulty in determining capacity is to regard it as a descriptive concept when it should, more properly, be seen as a normative concept. Wong and Clare suggest that there are three approaches to determining capacity: outcome, status and functional (Wong and Clare, 1999).

Outcome

12.15 Outcome as a measure of capacity considers the consequences of the decision making process. It tends to rest on conventional wisdom as a test of judgement and, as such, has been rejected by case law as it attaches little meaning or importance to self-determination (Wong and Clare, 1999).

Status

12.16 Status defines capacity through membership of a specific group or population or through the possession of a particular characteristic (Wong and Clare, 1999). Thus all adults are assumed to have capacity and children not to have capacity. Chronological age can be adapted to estimated ‘mental age’ where appropriate. Historically medicine (along with society) has regarded the ‘mad’ or those with a severe mental illness as lacking decision-making capabilities and this seems to persist through some current thinking. Psychiatric diagnosis, notably psychosis or schizophrenia, has been suggested as a characteristic or population lacking capacity. It would seem to require the person with mental illness to demonstrate that they have capacity and are competent rather than this being assumed and lack of capacity proven.

12.17 The main problems with the status approach are that it assumes homogeneity within the group and that all decision making requires equal capacity, or places equal demand on the person making the decision. Neither of these assumptions can be supported empirically. Again it is an approach rejected in case law.

Functional

12.18 A functional approach is based on establishing the extent to which the person’s capabilities meet the requirements involved in making the decision. This involves their understanding, knowledge, skills and ability to communicate among other abilities and relating these to the elements of the task within a particular legal context. This approach makes capacity both time-specific and situation-specific, or, as Winick describes it “a contextualised inquiry” (Winick, 1995).

12.19 This latter requirement means that it is not appropriate to use a standardised assessment of cognitive functioning but rather the need for a specific assessment in relation to the specific decision, for example, around the decision to take or refuse medication. Competency should not be seen as meaning the same thing in each context.
12.20 The functional approach leads to an interesting position. When a person is found to be lacking capacity the approach could be to consider what can be done to improve capacity rather than to automatically make a decision for him/her (Wong and Clare, 1999). Whatever functional abilities are lacking there may be opportunity to improve them through education, treating the underlying condition or presenting the information in a more accessible way. The circularity of some of these options is immediately apparent. Treating the condition that diminishes capacity may be the very issue on which consent is sought.

12.21 Such approaches as education and improving a person’s reasoning skills, also run foul of the problem of time-scale, in that they may be mid-to long-term solutions, when an immediate decision has to be made. That is not to say they should not still be employed with a view to future decision making. They are also likely to be time-consuming and thus expensive in resource terms. In the short term they are also time-consuming in that, in theory at least, such tests should be applied each time a decision is needed. The alternative is to presume capacity unless a clear reason can be given to question capacity. This is problematic because of the uncertainty concerning what is an appropriate threshold, but should mean that straightforward disagreement does not necessarily trigger capacity being questioned. There is no individual or societal agreement about the balance between respecting the autonomy of the individual, protecting that individual from harm, or indeed, protecting others from harm. This is reflected by the fact that legal standards for capacity vary.

**Integration of approaches**

12.22 Wong and Clare suggest that these different approaches could be integrated. The outcome and functional approaches could come together to form a sliding scale wherein the threshold depends on the complexity of the decision, the significance of the outcome or some combination of the two. There is still a problem with how and who defines the desirability or dangerousness of the outcome. Where this is determined by a clinician or, indeed, a lawyer the patient’s value system and abilities are likely to be undermined. This approach does nothing to help with deciding who sets thresholds (Wong and Clare, 1999).

12.23 A second combination would be to combine status and function, so that capacity is questioned in some groups and not others. This approach can be seen as discriminatory because it distinguishes people by membership of a particular group (e.g. with a mental illness) and may be prejudicial to people with disabilities (of various kinds). It has been argued that no distinction should be made between people with a mental illness and any other illness in law. It is, nevertheless, the approach suggested by both the Law Commission in England and Wales (1995) and in Scotland (Scottish Law Commission 1995).

**Characteristics of capacity**

12.24 If capacity is to be measured then it is necessary both to be able to define and measure the relevant abilities which make up capacity. The five main abilities are usually taken as: communicating a choice, understanding relevant information, retaining information, understanding/appreciating the personal significance of the information and arriving at a decision through reasonable and rational manipulation of the information given (Appelbaum and Grisso, 1995; Wong and Clare 1999). There is little debate about how much weighting should be given to each of these individual components.

12.25 There is, as might be expected, little research on capacity and mental health law. What work there is on capacity, awareness, insight and appreciation of information is usually carried
out with a view to contributing to knowledge about the illness, or to improving compliance
with medication, rather than as a study of decision making as such, let alone decision making
in relation to the law. Before considering what there is a few comments must be made about
methodological problems in such research.

**Methodological problems in research on capacity and decision-making**

12.26 A number of methodological issues exist in considering these studies. Mental illness is
not homogenous and thus there are concerns about the validity of comparing across diagnostic
categories or using undifferentiated groups of ‘patients with mental illness’. The reliability of
the diagnosis is also important when comparing within groups. Studies do not always have
clear diagnostic criteria and this can change between admission and discharge. Clear criteria
are needed to avoid unnecessary diagnostic heterogeneity.

12.27 As mental illness varies over time it is likely that competency will also vary. Measures
of competency and comparisons between groups and studies must take account of this.
Studies should, as a minimum, report symptom severity. Also, since competency is most likely
to be an issue at admission this would be the most appropriate time for studies to be carried
out.

12.28 There are no standard measures of competence or decision-making capacity that relate
to legal standards or requirements.

12.29 Practical and ethical problems beset the sampling frame. Patients must be asked if they
want to take part in research and must be competent before they consent. This means that the
patients who are of most interest to the research questions will almost certainly have to be
excluded. Since these studies are unlikely to be perceived as carrying a risk to the patient it
may be possible to set a low threshold for competence to consent to the study. Some ethics
committees take a broad view of risk/harm and express concerns that almost any interview
runs the risk of causing some distress to some patients. Guidelines for researchers and ethics
committees about involving potentially incompetent patients in non-invasive, non-risky
research, but which does not benefit the individual might be helpful.

12.30 Inevitably the most severely ill patients will not be able to take part because aspects of
the illness will prevent this. Studies rarely separate those who actively refuse to take part from
those who do not respond or otherwise more passively refuse. To separate the refusers
further into those who apparently know what they are refusing and those who do not would
seem to prejudge the issue, but would be helpful as a rule-of-thumb.

12.31 As a consequence of these sampling problems research data is likely to always
underestimate the degree of impairment and its prevalence in the most severely ill group of
patients.

12.32 A further problem with the research data is that much of it is old (from the 1970s and
1980s). Amongst other issues changes in diagnostic practice, particularly in the USA means
treating the early data with caution. Tightening of diagnostic criteria might be expected to
lead to a higher proportion of patients being deemed incompetent.

12.33 Finally, little of the research compares patients with a mental illness with patients with
physical illness or, indeed, with non-patients. Many patients lack information about their
condition and treatment (see sub-sections in Patients’ Rights and in Detention in Scotland:
patients’ knowledge of their rights from paragraphs 11.28 and 6.1 respectively).
Communicating a choice

12.34 Communicating a choice can cover a variety of issues ranging from language skills to the ability to make decisions. Although language skills is an issue for some people with learning disability who do not have speech, or only limited speech, this seems to be seen as a less serious impediment for people with a mental illness. The issue is more the nature of the communication as reflected in the decision made, although a patient may be so acutely ill that they do not even realise a decision is required of them. Patients who are mute or catatonic will be unable to communicate their decision, even if they are aware of what is happening. Other problems contributing to poor communication which can be overcome need to be checked, such as poor hearing or poor English. Indecisiveness may be a problem for some patients.

Understanding relevant information

12.35 Although there is a question of who decides what is relevant (for example, how much information is given about the side effects of medication, probable risks and benefits, alternatives to the treatment proposed) this is broadly an issue of what is relevant to the specific decision to be made for that individual. Information usually comes from the patient’s doctor and there is a question of how neutral he/she can be in presenting information and whether the patient perceives the presentation/information as coercive or not.

12.36 There is some evidence that people with depression and schizophrenia demonstrate a better understanding of information which relates to their own diagnosis than to medical information in general (Grisso and Appelbaum, 1996). This demonstrates the need for specific tests of capacity in relation to specific situations.

12.37 Patients’ ability to understand relevant information must be set against a background knowledge of what psychiatric patients generally understand about their illness and its treatment. Reviewing the literature Appelbaum and Grisso conclude that patients have an “alarming lack of knowledge regarding treatment” (Appelbaum and Grisso, 1995). A problem with these studies is that it is assumed that patients have been given information, that they paid attention and understood it at the time and that they have retained it. It is not possible to conclude that lack of knowledge has anything to do with mental illness rather than other patient characteristics including illiteracy, poor education or age. The 1990s saw a greater awareness of the need to give patients information about their illness.

12.38 Reviewing the literature on ability to understand information Appelbaum and Grisso point to a number of methodological problems which contribute to ranges of 19-43% of patients having poor comprehension (Appelbaum and Grisso, 1995). Studies between diagnoses have, however, suggested variously that thought disorder, organic impairment, psychosis and schizophrenia rather than depression predict poorer performance of understanding (Appelbaum and Grisso, 1995). This does not help, however, in assessing the individual.

Retaining information

12.39 This requires answers to questions such as how much information for how long and in what form? Is information only necessary for the length of time it takes to make the decision, or is it to be retained so that the rationale for the decision can be explained at some later date?
12.40 It could be argued that such a capacity is redundant since if the person has to demonstrate that they understand the information then they will, of necessity, demonstrate that they have retained it.

12.41 The studies referred to above can also be considered to be examining retention of information with all the same problems involved.
Appreciation of the personal significance of information

12.42 Appreciation here is an important concept because it means something different from mere understanding of the facts. In relation to decisions about treatment and health care it requires, among others things, the person to recognise that they have a disorder which needs treatment. This raises the thorny issue of lack of insight as a core component of schizophrenia and the clinical diagnosis of lack of insight. It would seem that lack of insight is equated with lack of appreciation, for most practical purposes.

12.43 Although accepted as a common core symptom, lack of insight is not present in all patients, nor in the same patient at different times. Its prevalence ranges from a high of 97% in an American study in the 1970s to a low of 27% in an English study in the 1960s (Appelbaum and Grisso, 1995). A review on the literature on insight is outwith the scope of this review.

12.44 There is also the question of whether the patient believes the treatment will help them (rather than a global understanding of efficacy). An individual may have a different appreciation of the benefits and risks of medication applied to them than as an abstract concept or as it is appreciated by their clinician.

12.45 Changes in insight over time may mean that current understanding of problems has to be separate from appreciation of problems in the past or potential problems in the future. Appelbaum and Grisso conclude that there are “conflicting results...on the degree of correlation among these dimensions” but that the appreciation of the need for treatment in both the present and the future are generally impaired (Appelbaum and Grisso, 1995). This may have implications for the provision of advanced directives.

12.46 Appreciation of understanding has also been studied in relation to depression, particularly in connection with hopelessness and helplessness. Although there is some evidence that depression might contribute to ‘realism’ by removing false optimism the findings are conflicting and complicated by the low threshold criteria used for depression in some studies. Mild depression may indeed be correlated with ‘depressive realism’ but severe depression is characterised by overt cognitive distortions. It is the latter category that is most likely to be considered for detention.

12.47 In studies with mixed groups of psychiatric patients it is not even possible to establish that lack of awareness is correlated with severity of symptoms, although better compliance with treatment and more positive outcomes would seem to be associated with greater insight (Appelbaum and Grisso, 1995).

Rational manipulation of information

12.48 The problem here, in relation to mental illness, is the inclusion of the word rational. The person has to weigh up the costs, risks and benefits of the decision for themselves (and others?) in a manner that others, usually clinicians, deem rational. Making a decision of rationality is essentially a subjective judgement and would seem to lead to an acceptance, covert if not overt, of an outcome approach to the decision. In common law irrationality, or unconventionality is not, in and of itself, indicative of incapacity.

12.49 If the outcome approach is to be avoided then the focus must be on the process by which the decision is made and which is assumed to be a logical process of comparing risks and benefits. It also involves understanding the individual’s underlying beliefs and values,
regardless of the apparent unusualness or irrationality of such beliefs and the part they play in the logical process. For such beliefs to be accepted as legitimate it is generally agreed that they should be long-held and not the result of a temporary delusion which is part of the current illness. A problem arises with this stipulation in a number of ways.

12.50 Some people have a long-standing, fixed delusion that is deemed part of their illness but does not vary with ‘acuteness’. How is such a belief to be interpreted in the light of the person’s underlying beliefs and value system? A perfectly rational process can proceed from unconventional beliefs. Decision making on the basis of long-standing belief does not take into account the belief system on which the decision is based and whether others regard it as pathological. The normative nature of competency is again an issue as judgements about an individual’s belief system are not value free but will reflect the values/belief system of the person making the judgement. This is a particularly important point in a multicultural society and has not been explored in terms of decision making and mental health law.

12.51 A different problem arises when a person with mental illness changes their mind about something we would see as fundamental, for example religious or political belief, which might then have an impact on their decision making. An extreme example might be someone who comes to adopt the beliefs of the Christian Scientists and who then rejects all treatment. It would seem that unless this pre-dated the illness there might be cause to question the belief. Since severe illnesses such as schizophrenia tend to develop while a person is still young (teens and early twenties) it would not be unusual for the person to go through a period of change in relation to political and religious belief. It would be unfortunate if people with mental illness were denied the opportunity to change their minds and allow new beliefs to influence their decision-making. Conversion is not necessarily a sign of illness, nor is it necessarily irrational.

12.52 It is doubtful whether rationality can be assessed without taking into account the outcome of the decision.

12.53 It is rarely spelt out that such a decision making process should take place in the absence of coercion. This is probably the least researched and least contested area of competency (Fadden and Beauchamp, 1986). Many would argue that the mere presence of mental health legislation, which allows detention and enforced treatment, is coercive.

12.54 Although there are a few studies on reasoning ability in people with a mental illness these tend to be abstract tasks. Given the previously noted finding that information about their own condition has more relevance for patients it would seem that in relation to legal decisions about capacity reasoning should be applied specifically to the case in point.

**Competence as a continuum**

12.55 The law requires competence to be a dichotomous capacity or state (the person is or is not competent) whereas it is more appropriately seen as a continuum. This applies to people with mental illness in particular ways. Even when their illness affects their decision-making capacity patients can still express choices, articulate how they arrived at their decision and exercise a degree of autonomy and rationality.

**TESTING FOR COMPETENCY**

12.56 There are very few studies that look at competency in psychiatric patients in a systematic way. The major piece of work, the MacArthur Treatment Competency Study is discussed below. Interestingly, although they study competency in an in-patient population
they do not correlate their measures of competency with the formal detention status of the patients.

12.57 One study in Ontario assessed the competency of 60 consecutively admitted patient meeting the criteria in the Mental Health Act of Ontario (Hoffman and Srinivasan, 1992). Of the 60 patients 44 (73%) were male and 16 (27%) were female. The age range was 18-68 years (average 38 years) and 88% were unmarried. The most common diagnostic category was schizophrenia (72%). Only 35% of patients were found to be competent through meeting all the criteria in the Act. The remaining 65% were judged incompetent in that they failed to meet at least one of the criteria and 48% did not meet any of the criteria of the Act. Although the number of women in the sample was small there did not appear to be a difference between the sexes.

12.58 Of the involuntary patients 86% were found to be incompetent and 44% of the voluntary patients. The authors report this is similar to other studies assessing competency and consent to treatment. There are, however, some differences with the MacArthur study although differences in the categories of competency make comparison difficult.

12.59 Although a broader definition of competency as, for example, used in the MacArthur study would allow more marginally competent patients to refuse treatment Hoffman and Srinivasan defend these narrower criteria as appropriate “in an educated society” (Hoffman and Srinivasan, 1992). They argue the need for operationalised measures of competency and for psychiatrists to use semi-structured interviews to assess competency. Finally they argue that, since any incompetent patient whether physically or mentally ill, requires the same service there should not be separate mental health law.

The MacArthur Treatment Competency Study

12.60 The problems with the research on competency and decision making capacity in mental illness lead to the MacArthur Treatment Competency Study (MATCS). This was an ambitious and brave attempt:

“to develop reliable and valid information with which to address clinical and policy questions regarding the abilities of persons with mental illness to make decisions about psychiatric treatment” (Appelbaum and Grisso, 1995).

This was to be done in the context of legal requirements for competency.

12.61 The measures developed were to assess the 4 standards of competency (choice, understanding, appreciation and rational manipulation) in relation to 6 criteria: (1) tasks related to legal standards of competence, (2) relevant to the current decision (i.e. to proceed or not, with treatment), (3) meaningful to the person studied, (4) standardised to allow comparisons within and between groups, (5) objective criteria, reliably scored, (6) practical in research and adaptable for clinical use.

12.62 Three instruments were developed; Understanding Treatment Disclosures (UTD), Perceptions of Disorder (POD) and Thinking Rationally About Treatment (TRAT) (Grisso and Appelbaum, 1995; Grisso et al. 1995) Each measure had a number of subtests. The UTS had three subtests; Uninterrupted-Paraphrase, Element-Paraphrase and Element-Recognition. The POD had 2 subtests; Non-acknowledgement of Disorder (NOD) and Non-
acknowledgement of Treatment Potential (NOT). TRAT is a complex measurement, scoring five problem-solving functions applied to one of several third-person vignettes. The second part of the TRAT assess reasoning in relation to transitive proposals and probability statements to determine the consistency with which personal preferences influence choice among alternatives. Expressing a Choice (EC) is one item of TRAT.

12.63 Three diagnostic groups were studied, schizophrenia and schizo-affective disorder, major depression and ischemic heart disease (angina pectoris) and a matched non-ill, non-hospitalised community sample in each of the 3 sites. Patients were recruited from three sites (Worcester MA, Pittsburgh PA and Kansas City, MO) although, oddly, not all groups of patients were recruited at each site (Grisso and Appelbaum, 1995; Grisso et al. 1995). Decision-making was studied shortly after admission. Up to one third of patients with a mental illness were re-tested after two weeks.

Understanding Treatment Disclosures outcomes

12.65 People with schizophrenia scored lower than non-ill controls on all 3 subsections, and people with depression on two sub-tests (Element-Paraphrase and Element-Recognition). There were no significant differences between the group with heart disease and the controls. Comparisons between the hospitalised groups indicated there were differences between those with schizophrenia and those with depression or heart disease. Poor scores on UTD correlated with symptom severity in the schizophrenia group while verbal cognitive functioning was positively correlated with UTD scores for the patients with depression. For both groups socio-economic status was positively correlated where paraphrased responses were required. Thought disorder, as measured by the Brief Psychiatric Rating Scale (BPRS) was positively correlated with UTD.

Perceptions of Disorder outcomes

12.66 Approximately one-third of patients with schizophrenia obtained very low scores on NOD but only a small minority of the other 2 groups. NOT showed a different pattern. Both patients with schizophrenia and depression were significantly less likely than the angina patients to acknowledge the potential value of treatment although at 13% of patients with schizophrenia and 14% of patients with depression it is still a minority who do not believe treatment to be helpful. There were no significant correlation with any other mental state or patient variables.

12.67 Patients with schizophrenia were most likely to devalue treatment, especially medication, because it was intended to harm them, whereas patients with depression most commonly believed they were “too sick” for anything to help them. Whether “harm” was related to previous experience of side effects is not known.

Thinking Rationally About Treatment outcomes

12.68 Both patients with schizophrenia and depression scored significantly lower than their matched community group on the TRAT whereas there was no significant difference between patients with heart disease and their control group. Both patients with schizophrenia and depression scored significantly lower than did patients with heart disease. Comparing TRAT with BPRS scores showed no significant correlation, but there was a trend relating poor scores with thought disorganisation as demonstrated with UTD.
Expressing a choice (EC) was part of the TRAT. The choice involved making recommendations about treatment to a hypothetical person. Only 5% of all respondents could not state a preference, usually because of extreme ambivalence. Of the different groups, 3% of patients with schizophrenia, 8% of patients with depression, 4% of patients with angina and 12% of community patients failed to state a preference.

**Inter-relations between outcome measure**

UTD and TRAT scores were “modestly correlated” but there was poor correlation with POD. Looking at patients who have impairment on all measures, patients with schizophrenia have higher proportions than the other 2 groups, with up to one quarter of patients with schizophrenia doing poorly on any given measure.

Patients performed unevenly across measures, so that about 75% of patients with schizophrenia performed adequately on at least one measure. Only 48%, however, have adequate performance across all 3 measures compared with 76% of patients with depression, 88% of patients with angina and 96% of the community control group.

Overall the study found although patients with mental illness showed more performance deficits than the other groups there is still “considerable heterogeneity” within and across patients with schizophrenia and depression. Although patients with schizophrenia performed less well as a group this is due to a minority of patients. The majority of patients with schizophrenia did not perform more poorly than other groups. Those patients with schizophrenia who perform less well were more likely to be more severely ill, especially showing thought disturbance, but there were no other demographic, mental state or patient characteristics which distinguish them (Grisso and Appelbaum, 1995).

**Limits to the study**

The authors note two “important conceptual matters” which limit the interpretation of the study (Grisso and Appelbaum, 1995). The first is the sampling problem noted earlier: a number of patients were excluded because their doctors believed them too acutely disturbed to take part. This means the findings will underestimate the numbers with very poor performances. Interestingly, the proportion of those excluded related more to hospital site than to diagnosis.

The authors are clear that the experimental measures developed for the study should not be treated as though they determine legal incompetence. The variability of determination of legal incompetency across jurisdictions and between judges would make such comparisons inappropriate. Neither do these measurements equate to the degree of deficit in ability that a judge must decide warrants a decision of incapacity. Impaired on these measures relates to the infrequency of scores below a threshold.

Nevertheless, the authors believe “that the measures do provide meaningful representations of the decisional abilities” considered by the courts. They do, however, seem to suggest that there may be a problem with false positives and that those with a low score “might best be seen as ‘at greater risk’” of failing to meet the threshold of abilities which would determine legal competence.

Other commentators have, however, found more to concern them with this study and an entire issue of *Psychology, Public Policy and Law* (1996 2 (1)) was given over to...
evaluating the study with the study’s main investigators, Grisso and Appelbaum given an opportunity to respond. The measures themselves come under criticism.

12.77 The UTD, which measures understanding is criticised by lawyers Kirk and Bersoff because of its reliance on the patient’s ability to recall and paraphrase information (Kirk and Bersoff, 1996). They question how necessary such abilities are in making decisions about treatment.

12.78 The POD, which operationalised appreciation is criticised by Slobogin. The NOD, he argues, is objectionable on normative grounds, as there may be good reasons why someone denies they have a mental illness (Slobogin, 1996). These could include non-acceptance of the concept of mental illness in general, avoidance of labelling and stigma, the individual may not feel ill or they may prefer the symptoms to the cure. In like vein he argues that refusal to acknowledge the value of treatment (NOT) does not, necessarily, reflect impaired judgement. Non acknowledgement of disorder, he suggests, would be improved by linking denial to symptoms rather than disorder and not to whether the patient’s beliefs about treatment have any foundation. A further problem with the measures is the use of standardised information about treatment and consequences, rather than personalised information.

12.79 Kirk and Bersoff broadly agree with this position, arguing that acknowledgement of illness and potential value of treatment are inappropriately equated with the level of appreciation necessary to take part in decision making about treatment (Kirk and Bersoff, 1996). They agree with Slobogin’s suggestions of why a person may not acknowledge having a mental illness.

12.80 In discussing these points Grisso and Appelbaum agree with many of the comments.

“When a failure of appreciation is related to simple ignorance, the proper response is education not a declaration of incompetence. When it is related to difference in values, the proper response it to respect the patient’s choice” (Grisso and Appelbaum, 1996).

They do, however, question whether the only criteria for a “patently false belief” is one based on delusion and suggest other reasons for denial which might lead to a decision of incompetency, including parietal lobe damage or intolerable anxiety related to recognition of the disorder.

12.81 Grisso and Appelbaum do accept, however, that nothing in the POD allows for a decision to be made on whether the patient’s denial/refusal is based on a “patently false belief”. Thus “the POD falls short of operationalizing the lack of appreciation with which competence judgements are concerned” (Grisso and Appelbaum, 1996). The reason for this they explain as following “considerable intellectual struggle, we despaired of finding a standardised, reliable way to identify a ‘patently false belief’”. They argue that for “practical purposes, the clinician’s art may be able to differentiate the disordered from the acceptable”.

12.82 Stefan raises the question of whether reliance on acknowledgement of illness introduces a racial bias into the assessment and, indeed, promotes racism (Stefan, 1996). Black men, Stefan reminds us, are more likely to deny their illness when in mental health settings. The POD largely relies on disagreement with the clinician’s assessments to determine incompetence. Any group, therefore, who is more likely to disagree with clinicians is also more likely to be found incompetent. Noting this point Grisso and Appelbaum analysed their data to consider this point and found no difference for African American men or women against other men or women (Grisso and Appelbaum, 1996).
12.83 The TRAT is also criticised by Kirk and Bersoff for relying on problem-solving skills to measure reasoning (Kirk and Bersoff, 1996). They question whether deficits in problem-solving skills should justify involuntary hospitalisation and involuntary treatment, especially with psychotropic medication.

12.84 Slobogin and Kirk and Bersoff argue that the definition of impairment is too broad in the measures generally. (Kirk and Bersoff, 1996; Slobogin, 1996). They question the legal standards of competency in state law generally and criticise MATCS for basing their measures on these. They argue that the law requires a higher level of competency to refuse psychiatric treatment than to refuse medical treatment, and that the law sets competency standards too high. Kirk and Bersoff express concern that:

"If policy makers and legal decision makers rely on the MacArthur instruments when making competency determinations, standards for treatment competency may become even more stringent, threatening the autonomy of mental health treatment refusers" (Kirk and Bersoff, 1996).

They suggest that a narrower standard of incompetency, limited to situations where the individual cannot communicate a choice, cannot understand the risks and benefits of treatment or whose decision making is clearly the consequence of delusional thinking, or extreme confusion, would be more appropriate.

12.85 Stefan’s concern with racial bias takes in the fact that proportionately blacks are over-represented in hospital populations and that there are significant associations between diagnosis, socio-economic status, perceived and legal voluntariness and acknowledgement of illness with race and determination of competency (Stefan, 1996). The MATCS data is not analysed by either race or gender, but Stefan points to a difference between the groups in terms of membership of racial minorities. In the group with schizophrenia 46% come from racial minorities, in the group with depression 37% but in the group with angina only 7% were from ethnic minorities. If competency is agreed to be situation specific it is also likely that culture will effect this both in terms of belief and interpersonal dynamics. Grisso and Appelbaum point out that the community groups were matched for age, gender, race and socio-economic status and suggest that this overcomes any bias (Grisso and Appelbaum, 1996).

12.86 Kirk and Bersoff’s discussion goes beyond the limitations of the MATCS to question the law. Much of their argument stems from their concerns about the involuntary use of psychotropic medication and that such drugs are not a cure, are not effective for all patients and may bring with them serious side effects. In the light of this they argue that only rarely should the state’s interests in involuntarily medicating someone outweigh the rights of that person to refuse it. They conclude that judicial rather than clinical or administrative determinants of competency are appropriate along with conservative time limitations on involuntary medication and frequent monitoring. These more general comments raise questions as to whether it is even appropriate or legitimate to develop psychometric measures to encompass a legal concept such as competency. The potential for misuse of such instruments is explored.

12.87 Kapp and Mossman refer to such an instrument as a “capacimeter” and in exploring this describe any attempt to develop such an instrument as inherently flawed (Kapp and Mossman, 1996). Some of these objections could be overcome. That the different states currently have different standards for defining competence does not preclude the possibility of one standard being adopted (even if this seems unlikely). Likewise the problem in the
selection of patients to undergo assessment for competency being biased by clinical judgement could be overcome by requiring everyone to be assessed for competency (either for any psychiatric treatment or for all medical or surgical treatment). This might be time consuming, expensive and unnecessary, but it is possible.

12.88 Grisso and Appelbaum respond by pointing out that they had never intended their research instruments to be anything other than a research tool and that these measures are too long and complex for standard clinical use (Grisso and Appelbaum, 1996). They have, however, developed a clinical assessment.

12.89 More important reservations stem from the belief that competency is dynamic, that it fluctuates over time and thus it is intrinsically difficult to base a decision about competency on a single point in time. Kapp and Mossman have particular concerns for elderly people with dementia that such forms of competency assessment might produce too many unnecessary guardianship orders.

12.90 Roesch, Hart and Zapf also support this view, arguing that psychological tests take a structured sample of behaviour and use this to make descriptive, predictive and comparative judgements (Roesch et al. 1996). The law, as they point out, has a narrower focus and deals only with an individual in a particular situation. They suggest that the law’s need to make a categorical decision (competent or incompetent) is incompatible with psychometric testing.

12.91 If, however, the question is can the individual make a competent decision at this point in time and the assessment is seen to reflect this, then this concern can be managed. To maintain an involuntary order appropriately, however, might require frequent reassessment of competency. Kapp and Mossman suggest that instruments such as those developed in MATCS can best function as screening tools. Competency, they argue, is neither objective nor binary and that it would be preferable to define clinical parameters of competency along a continuum.

12.92 Roesch, Hart and Zapf argue that although such measures may be useful in clinical and research settings and may, in any setting make assessment more systematic, nevertheless they are of doubtful use in a legal context (Roesch et al. 1996). Grisso and Appelbaum agree that competence to consent to treatment can never be definitively determined (Grisso and Appelbaum, 1996). The problems include those already cited: the identification of abilities related to specific legal jurisdictions; the need to interpret reasons for poor performance and the need to establish threshold. They also observe that the legal decision is “ultimately moral in nature” requiring, as it does, judgements about patients’ interest “based on applications of the values of autonomy and beneficence”.

12.93 The lawyer, Winick, who edits this special issue of the journal concludes that the MATCS may well have important legal implications as it challenges the view that mental illness deprives people of their ability to make decisions. He suggests that the study would support the presumption of competence and also support the right to refuse mental health treatment (Winick, 1996). Grisso and Appelbaum point to the need for caution in concluding that any data can resolve questions that are intrinsically normative (Grisso and Appelbaum, 1996).

12.94 Wider issues, raised in other papers relating to the MATCS, such as the way counsel relates to individuals who may or may not be competent are dealt with in the other relevant sections of this review (Perlin and Dorfman, 1996; Winick, 1996). Roesch, Hart and Zapf consider the implications in relation to criminal competence and ability to stand trial. Criminal competency is outwith the remit of this review and will not be considered further.
CHAPTER THIRTEEN: MINORITY GROUPS

13.1 As well as the more usual minority groups older people and people with learning difficulties have been included in this section as, in terms of the numbers involved in the detention under the MHA they are minority groups.

ELDERLY PATIENTS

13.2 There is little specific work on the use of mental health legislation in the over 65 years population and most of what there is applies to the use of guardianship and incapacity (see sections on guardianship and incapacity from paragraphs 5.1 and 12.1 respectively). The elderly population with ‘mental infirmity’ (senile dementia) have been singled out as presenting special problems and needing special consideration as the Mental Health Act does not fully address these patients (Morris and Anderson, 1994).

13.3 The National Assistance Act 1948 (NAA), section 47, can be, and is used to detain this group of patients if necessary. Indeed 90% of the people for whom it is used are over 65 years. Most of these people are in poor physical health and have a major psychiatric disorder (Wolfson et al. 1990). This is of concern since Section 47 does not have the same safeguards as the Mental Health Act and it raises questions as to why it is used in preference to the MHA. Also, it has no power to treat.

13.4 Detention under the MHA increases for women with age. Once past 30 years more women are detained than men, and substantially more in the over 65 years group (Hatfield et al. 1992).

13.5 Gilmore et al carried out a retrospective case note review on all patients over 65 years old in Southport health district in the six years after the introduction of the 1983 Mental Health Act (Gilmore et al. 1994). One hundred and twenty patients were involved in 132 episodes of detention. Of these, 53% had an organic and 47% a functional illness. Seventy per cent were women. Section 2 was used in 86% of cases and 80% of the patients were admitted from their own homes. Patients with dementia were significantly older. For patients with dementia, hazardous behaviour, self-neglect and a carer being unable to cope were the most common reasons for detention. For those patients who lived with a carer, the carer’s inability to cope was the most common reason (56%) for detention. Self-neglect was the most common reason (50%) for people with dementia who lived alone. Of these 58% were discharged to a nursing or residential home. Patients with a functional illness were most likely to be detained for their own health. Only 6 of these patients were detained for the protection of others. Mortality in the detained patients was significantly higher than for the general population. Twenty-seven percent died within a year of being detained. Only 9 MHRTs were held and this was seen as of some concern.

13.6 The authors conclude that the use of the Act is different for the 2 groups of patients, as are their needs. It was suggested that admission for some patients had been delayed until a crisis occurred (Gilmore et al. 1994).

13.7 This general pattern appears to be repeated in a slightly later study (1989-1991) at a psychogeriatric hospital (Feehan, 1994). Of 621 admissions 5% were detained of whom 80% were under section 2 and 71% were female. The most common reason for detention was self-neglect associated with inadequate food and liquid intake. No relative made an appeal on behalf of the patient.
13.8 Morris and Anderson looked at 32 patients admitted to a district service during 1991-1992 (Morris and Anderson, 1994). Of these 75% were female and 64% had a functional illness. Forty-two percent were detained under section 2 and 50% were detained under section 3. Patients with dementia were most likely to be detained under section 2 and patients with functional illness under section 3. In 55% of cases deteriorating mental state was the main reason for detention but in 28% of cases the patient was on section 3 before requesting a second opinion for ECT. The majority of the patients (82%) were living at home on admission but only 39% were discharged to home. Three (9%) of the patients died. Only 24% of the patients with a functional illness were classified as recovered, although 62% made at least a moderate improvement.

13.9 The authors point out that it is not the intention of these sections of the MHA to facilitate entry into residential care and they suggest that no available legislation, including the NAA, makes adequate provision for this group of patients (Morris and Anderson, 1994).

13.10 A study in Israel in 1992-1993 indicated that 8% of all detentions related to people over 65 years of age and showed some different patterns to those in Britain (Heinik and Kimhi, 1995). The number with organic conditions (approximately 25%) was lower than in Britain and there were approximately equal numbers of men and women in the group of patients with dementia. Detained patients with dementia were a small minority of all patients with dementia and for 79% this was their first admission to a psychiatric hospital. Most patients in all diagnostic groups were in hospital for less than one month. They were most likely to be discharged supported by the hospital and referred to non-ambulatory care in non-psychiatric institutions.

13.11 A study in Southend by Srikumar and Orrell compared the characteristics of detained patients who were under 65 years with those over 65. The period covered was January 1987-September 1993 for patients over 65 (82 patients) and the years 1989 and 1992 for those under 65 (81 patients). Women accounted for 65% of the over 65 group and 47% of the younger group. Twenty-five per cent were married in each group, but whereas 57% of the younger group were single (presumably never married) only 21% of the older group were. Of the younger patients 31% lived alone whereas 58% of the older group did, a highly significant difference (Srikumar and Orrell, 1995).

13.12 Older patients were more likely to be in touch with CPN services before detention (27%:9%) whereas younger patients were more likely to be attending an outpatient clinic (36%:15%). Almost half (47% in both groups) were not receiving any services prior to the detention. Few received other services. Nine elderly and one younger patient received home help, 2 elderly patients attended a day centre and one elderly patient received meals on wheels.

13.13 There were some differences in the mode of referral. Although the majority of all patients were referred initially by their GP (88% of elderly and 54% of younger patients) for the elderly it was significantly more likely to be their own GP (78%:48%). Younger patients were more likely to be referred by the police (33%:6%) and to have the police involved in some way in the admission (53%:18%).

13.14 Almost everyone had a social worker involved in the detention (100% elderly, 95% younger patients) and relatives were consulted in a minority of cases (35% elderly and 29% younger patients). There were no significant differences in the use of section 2, 3 or 4. Section 2 was used in 67% of cases for elderly patients and for 54% of younger patients and section 4 for 37% younger and 22% elderly patients. The majority of patient were admitted out-of-hours (63% elderly and 70% younger patients). A non-significant trend showed that
more elderly patients were admitted in the winter than autumn (36%:20%) which was reversed for younger patients (17%:31%).

13.15 Reasons for detention indicated that everyone was a danger to their own health and safety but younger patients were significantly more likely to also be a danger to others (74%:45%). There were some significant differences in the behaviour/symptoms cited as reasons for compulsory admission. Younger patients were significantly more likely to show aggression or violence (75%:49%) and to present a suicide risk (16%:5%). Older patients were significantly more likely to show self neglect (44%:14%), not eating or drinking (28%:6%) and wandering (15%:5%). There was no difference in hazardous behaviour (12% elderly and 15% younger patients) and failure to cope (7% elderly and 5% younger patients).

13.16 A minority (21%) of elderly patients had a diagnosis of dementia or delirium (4%) and no younger patient. Approximately equal percentages of patients with depression (18% elderly and 20% younger patients) and schizophrenia/paranoid states (43% elderly and 49% younger patients) were admitted, but more younger patients with mania (26%:14%). Five percent of younger patients had a diagnosis of alcohol/drug dependency but no older patients.

13.17 Following a logistic regression analysis the two variables which best differentiate between the 2 groups indicate that elderly patients are more likely to be living alone and less likely to require the involvement of the police. Living alone may be a risk factor for the elderly person with a psychiatric illness since 58% of elderly patients admitted lived alone compared to 30% of the elderly in the local community. The increased number of women, however, was in line with population figures(Srikumar and Orrell, 1995)

13.18 Concern with protecting the rights of people with dementia and the management of their financial and personal affairs in Scotland lead to the suggestion that Mental Health Hearings, modelled on Children’s Hearings, be established. Davison et al investigated this in the Renfrew District and Glasgow (Davison et al. 1993). Over 60% of professionals who responded to a postal questionnaire thought that a Hearings system would be very or quite likely to be helpful. Fifty percent thought that it would have been in their most recent problematical case. Further interviews suggested that most people saw Hearings as positive although there was some concern about their challenge to professional judgement and pre-existing groups within social work departments.

13.19 Carers, however, were less enthusiastic. “They were generally against any erosion of the informality of current procedures” and the intrusion of the state into family matters. Concern was also expressed about the ability of lay people to make decisions about people with dementia. The link with the Children’s Hearings was of concern and the perception of investigations of wrongdoing and the panel as a kind of court featured strongly.

LEARNING DISABILITY

13.20 Reviewing the literature, Whitworth and Singhal find that a number of authors have been reluctant to use section 7 for guardianship orders because the Act refers to ‘mental impairment’ rather than ‘mental handicap’. It also associates ‘arrested or incomplete development of mind’ with ‘abnormally aggressive or seriously irresponsible conduct’ (Whitworth and Singhai, 1995) This would seem to exclude the majority of people with learning disability that are not abnormally aggressive. The authors suggest that “seriously irresponsible conduct” is being broadly interpreted to protect patients who are “vulnerable and subject to abuse and neglect” (Whitworth and Singhai, 1995)
As with the elderly, much of the research on this group of patients is found under guardianship. There have been several studies that describe the population. Detained patients with a diagnosis of learning disability are mainly male, young and detained for violent or “challenging behaviour”. Of 33 patients with learning disability detained only one did not have a concomitant psychiatric diagnosis and half had a serious mental illness (Kon and Bouras, 1996).

Alexander and Singh look at the use of the MHA in a tertiary assessment and treatment facility for people with a learning disability in the North West Thames area for the year 1997. Twenty-nine patients were detained, with 5 patients being detained twice, giving 34 episodes of detention (Alexander and Singh, 1999). Of the 34 episodes 68% (23) related to male patients with a mean age of 36, while the female patients had a mean age of 30. Aggressive or violent behaviour accounted for detention in 77% of cases, while other reasons given included self-neglect (29%), disinhibition (6%) wandering (6%) and low mood (9%).

The legal categories used were mental disorder (24%), mental illness (50%), mental impairment (56%) severe mental impairment (12%) and psychopathic disorder (6%). The commonest combination of categories was mental impairment and mental illness (32%). The diagnoses after admission was schizophrenia (32%), bipolar disorder (21%), depressive disorder (21%), alcohol dependence (6%), dissociative personality disorder (6%) and autistic or autistic spectrum disorder (18%). Only 21% of patients had behavioural disorder as the only diagnosis. These 7 patients (4 males, 3 females) presented with aggressive behaviour in 6 cases and one had wandering and self-neglect (Alexander and Singh, 1999).

As with the previous study, the majority were males with aggressive behaviour. A large number had a serious mental illness as well as having a learning disability. The authors suggest that teams should undertake a systematic evaluation when presented with severe challenging behaviour to rule out the possibility that it might be caused by mental illness.

An earlier study looking at patients detained in a mental handicap hospital for the years 1980-1990 found that 43% of patients detained had a mental illness; 43% were detained because of “subnormality” or “impairment” (Langton and Krishnan, 1993). Of those detained 70% had a mild mental handicap. This was a young population, with 60% under 30 years and only 15% over 40 years. The numbers of new patients did not change much over the 10 years. Length of stay decreased, however, leading to fewer patients detained at any one time. The decline in numbers over the period was entirely accounted for by the decline in patients with mental impairment. Patients with a primary diagnosis of mental impairment were likely to have a longer admission (76% for more than 6 months) whereas those with ‘mental illness’ were more likely to be detained for less than 6 months.

Langton and Krishnan suggest that the changes over the period were due to the introduction of the 1983 Act, a decline in beds and increase in community provision and a change in attitudes of staff and cares.

WOMEN

Although in the over 30 age group women are more often detained under the Act than men we have found no specific research relating only to women.

ETHNIC MINORITIES
13.28 Reviewing the literature on inequalities in mental health Henderson et al conclude that African-Caribbean people have twice the rates of mental illness as white people (Henderson and Thornicroft, 1998). The admission rates for African-Caribbean people with schizophrenia are 3-5 times higher. Second generation African-Caribbean people seem to have higher rates than do others. African-Caribbeans are also less likely than other groups to be satisfied with mental health services.

13.29 Although this review is unable to consider all the literature in this area the possibility of over diagnosis of other races by white British psychiatrists must be considered. Hickling et al compared the diagnoses of a black Jamaican psychiatrist with his white British colleagues and a CATEGO diagnosis using the Present State Examination (PSE) (Hickling and McKenzie, 1999).

13.30 The black patients were 6 Caribbean born and 23 UK born African-Caribbean. Nine were of African origin, 2 were from Mediterranean Europe, one was of Indian origin and one was of mixed parentage (total 42). There were 24 white patients. Those in the black group were significantly younger.

13.31 There was no significant difference in the populations people diagnosed with schizophrenia between the British and Jamaican psychiatrists although there was a relatively low level of agreement (55%) on which patients had schizophrenia. The most common alternative diagnosis was mania.

13.32 The CATEGO program diagnosed more people with schizophrenia (65%) than either the British psychiatrists (55%) or the Jamaican psychiatrist (49%). The authors suggest that the high rates in studies relying on the PSE need to be re-evaluated.

13.33 Cultural issues are only relevant to migrants to a different culture but both Western psychiatry and the law itself can be imposed on another culture. Schultz-Ross and Jenkins (1998) give the example of Hawaii and suggest that:

“police and authorities might be forced to operate on cultural beliefs distinct from the people, such that the workings of the law do not have personal meaning or the ring of justice for the people involved” (Schultz-Ross and Jenkins, 1998).

13.34 They cite criminal trespassing as a common means of admitting people to hospital and contrast this with the lack of a concept of private property before Hawaii had contact with, and was taken over by, an outside nation. They suggest that given

“the imposition of private property into Hawaii, the later use of this law as a means of caring for the mentally ill is particularly disturbing” (Schultz-Ross and Jenkins, 1998).

13.35 One problem in researching the law in relation to ethnic minorities is the lack of ethnic monitoring at key points in the criminal justice system and in some NHS records (Browne, 1990). A study carried out by the National Association for the Care and Resettlement of Offenders (1998) found a small number of cases remanded for psychiatric reports in magistrates’ courts (70 out of 38,000). African/African-Caribbean defendants made up one third of this group and were more likely to be remanded in custody than whites who received

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4 CATEGO is the computer program which produces a diagnosis based on PSE data
bail. They were also more likely to receive a psychiatric disposal, be it a hospital order or a psychiatric probation order.

13.36 Davies and Thornicroft suggest that African-Caribbean people with schizophrenia are more likely to be compulsorily detained than whites (Davies and Thornicroft, 1996). Pipe et al looked at all section 136 referrals by police to a South London hospital and compared white patients with African-Caribbean/African patients (Pipe et al. 1991). Other ethnic minority groups were excluded. The sample of patients was 21% black to 5.5% in the local population which is slightly significant. The disproportionate numbers were African-Caribbean males between 20-29 years (83%). Although not significant, black patients were more likely to be single, to be living in stable accommodation, to be perceived as threatening, incoherent and disturbed. Denial of illness was more frequent and they were more likely to have a diagnosis of both personality disorder and schizophrenia. Black patients were three times more likely to have had a previous section 136 referral to the hospital. Blacks were twice as likely as whites to be recorded as not ill by duty doctors. Blacks were also less likely to have made contact with their GP within the six months of discharge.

13.37 The authors record that that their findings are in line with earlier studies, and although raising questions of discrimination and racism suggest that:

“it is possible that the situation reflects a largely appropriate use of section 136 in its present form, in which case the argument for a wide-ranging review of current service delivery becomes more pressing” (Davies and Thornicroft, 1996).

13.38 A consideration of the work on whether, and why, ethnic minorities are over-represented in the mentally ill population is outwith the scope of this review. It is, however, generally accepted that African-Caribbean people are proportionally over-represented in detentions under the Mental Health Act. It may be that this is a result of their over-representation in the mentally ill population.

13.39 The picture for Asian populations is less clear with contradictory findings (Hatfield and Mohamad, 1996). A study of the attitudes of Asians to mental health services in a Northern Metropolitan Borough finds that of the sample 56% had entered the community as adults (16+ years) and that the women two-thirds had come as an adult. This was reflected in language difficulties (46% of the total group, 50% of the women). Many of the findings were no different from what would be expected of white respondents (eg concern over drug side effects, lack of careful explanations of treatments) but the importance of religion (Islam) was felt to be underestimated and misunderstood by mental health services (Hatfield and Mohamad, 1996). The study did not look at detention.

13.40 The part that culture plays in the diagnosis of mental illness is not considered, but some reference is made in relation to capacity from paragraph 9.83. There is some suggestion that research into ethnic minorities and mental health may be specific to both ethnic group and the part of the country where it is carried out and that work, for example, in London may not always relate to the position of ethnic minorities in Scotland.

13.41 There are difficulties in monitoring the use of the MHA in ethnic minorities since routine monitoring of ethnicity has only recently been seen as necessary. The MWC does not routinely collect data on ethnicity.

13.42 One area that has not been researched as such but probably plays a part is institutional racism. This led to the title of a Special Hospitals Service Authority report on three deaths of
patients as “Big, Black and Dangerous” (Special Hospitals Service Authority, 1993). This report concluded that institutional racism is most commonly seen as acts of omission. In the case of Orville Blackwood at Broadmoor, for example, they conclude that staff did not appear to use their wider psychiatric skills to manage Blackwood’s deteriorating condition, but instead relied on seclusion and intra-muscular medication.

13.43 Crichton suggests that it may be “unreasonable to ask nurses to be both warder and therapist” and points out that some American secure hospitals separate these duties to different staff (Crichton, 1994).

HOMELESSNESS

13.44 The special problems of people who are homeless and have a mental illness have been highlighted. However, there is little research on this group apart from that encompassed by the court diversion schemes which were set up because of the concern about the inappropriate use of criminal law to manage this group of people (Abdul-Hamid and Cooney, 1997).

13.45 Section 136 of the Act is commonly used with homeless mentally ill people which gives the police powers to remove a person apparently suffering from a mental illness from a public place to a place of safety (Abdul-Hamid and Cooney, 1997).
CHAPTER FOURTEEN: ATTITUDES TO PSYCHIATRIC ILLNESS

14.1 Although not referring specifically to mental health legislation a number of articles dedicated to or highlighting attitudes to people with mental illness and care in the community in Scotland were identified through hand-searching and secondary referencing. This relates only to research in Scotland.

14.2 Attitudes of the general population were investigated by sending a vignette and questionnaire to 280 members of the public randomly selected from the Lothian telephone directory (Lawrie, 1999). A response rate of 41% was achieved accounting for 103 analysed returns after those that had moved or deceased were discounted. The vignettes described a visit from a neighbour who was known to have schizophrenia (25 responses), depression (29), diabetes (28) or no illness (21) and asked questions designed to assess the level of sympathy and willingness to socialise with them. Levels of agreement to these questions appeared to suggest that the person with schizophrenia might expect a level of social distance equivalent to that of the healthy control whereas responses to the person with diabetes or depression inclined towards receiving a more positive response. These results indicated a trend towards significance. The poor response rate meant that there was a low power to detect statistical significance. The possibility of response bias cannot be ruled out but social class coding amongst those that did respond was broadly representative.

14.3 The only statistically significant results were found in the proportion of people who knew someone with one of the illnesses. Not surprisingly, fewer people knew someone who had schizophrenia but those who did were less likely to be sympathetic or sociable towards this hypothetical neighbour. Philo’s study of the influence of the media on public belief also found evidence for this (Philo, 1996). In 13 cases (21% of the study sample) people with psychiatric illness were perceived as violent despite this being contrary to the respondent’s personal experience. These subjects traced this view to an “overlay” of media influence. This is important because received wisdom (and research in other areas) suggests that personal contact with a stigmatised group would reduce the incidence of stigma and hostility.

14.4 Lawrie also surveyed GPs using a postal vignette research instrument and found that they were less willing to treat a patient with schizophrenia as compared to one with another illness (Lawrie et al. 1996). A later survey confirmed this and also interviewed a few in-patients who had psychotic illnesses who held that they expected more discrimination from GPs and psychiatrists than the general public (Lawrie et al. 1998).

14.5 A highly significant factor in the North American concept of Service Dependant Ghetto Formation is held to be the impact of local community opposition to care in the community facilities on local government (Dear and Wolch, 1987). The siting of the Huntington Day Hospital in the Dumfries and Galloway area revealed strong opposition from the residents in the proposed area in the consultative period (Milligan, 1996). Over 67% of the housing within the immediate locale of the day hospital were in the uppermost council tax banding. The characterisation of a rejecting neighbourhood as both strong and predominantly middle-class (as represented in the North American model) was affirmed in this case. However, where vociferous local objections were found to be an effective tool in overturning, adjusting or re-siting similar planned resources in North America, it had no impact on the original plans for the character and location of the unit in Dumfries and Galloway despite organised and articulate opposition. The British system of centralised planning control, differences between the health systems in Canada and the UK, including central government
commitment to community care, were cited as the reasons for the different outcomes in similar
locations and models of care provision.

14.6 Because conversion of family residential property to small residential accommodation
units does not constitute a change of use under Scottish law there is no need to advertise to or
consult with interested parties or to apply for planning permission. A small number of people
were interviewed some time after the opening of the day hospital. Perhaps the most significant
finding of this was the apparent lack of awareness concerning two five-bedroom hostels for
people with mental health difficulties, run by the local Mental Health Association and situated
in the same street as the day hospital (Milligan, 1996). This would seem to support the view
that this low-key approach to residential and supported accommodation within the community,
broadly adopted by voluntary agencies, is also advantageous in terms of local acceptance.
CHAPTER FIFTEEN: RESEARCH AND MENTAL HEALTH LAW

15.1 This review exercise has highlighted the lack of research or audit on the use of mental health law in Scotland either in terms of process or outcomes. For the section on the law in Scotland we have relied heavily on data reported in the annual reports of the Mental Welfare Commission for Scotland. The lack of research and data is unfortunate since the size of Scotland means it is well placed to carry out good, national studies on total populations of patients affected by mental health law. Good monitoring of the new law would seem particularly important since in a number of the studies previously referred to expectations were not met in reality.

15.2 This section will consider both practical and ethical issues relating to research on mental health law, why there might be a lack of research and how this could be improved in future in Scotland.

CONSENT TO RESEARCH

15.3 One difficulty in investigating many issues relating to mental health law is the mental health status of the patients involved and their ability to consent to research. As has been noted in a number of studies, acute illness or lack of capacity means that many patients are excluded from interview/assessment type studies. This is particularly unfortunate when it is competency that is under investigation.

15.4 Other research requires access to the case record. Where this can be suitably anonymised then there should be no ethical objections. There are, however, concerns expressed when named data is needed, for example for follow up.Whilst patient confidentiality must be respected it would be helpful to consider whether, in some cases, non-invasive research, particularly in relation to case record studies but also possibly interviews, might not be sanctioned where patients are unable (or might be unable) to consent.

15.5 Two studies by Stanley and colleagues suggest that patients with a variety of diagnoses take idiosyncratic approaches to research participation. In one study 40% of acutely ill and hospitalised patients agreed to participate in a high-risk/low-benefit hypothetical research project and 32% refused low-risk/high-benefit research (Stanley et al. 1982). They found no difference between psychiatric in-patients and medical in-patients (Stanley et al. 1981).

NATIONAL DATA BASE

15.6 Currently the use of the MHSA is notified to the MWC. This allows trends in the use of the Act to be monitored, but for more detailed research or understanding of the impact of the Act there would need to be an agreement on data which was to be routinely collected in a standard way. At the moment, for example, it is not possible to make any comment on the use of the MHSA in ethnic minorities since data on ethnicity is not routinely collected.

15.7 Other information, such as use of services, could be collected both at time of detention or discharge. At present such information is collected and reported in case notes, following visits, for example, and is not standard, either in content or recording. Our previous research on use of ELOA, for example, was only able to give indications (of minimum use) of services by patients since this is not collected or recorded in a standard way, but depends on the concerns of the person making the visit. This is unfortunate since MWC records could form
an important, and potentially easily accessible, source of information to monitor the impact of the use of the law on patients in Scotland.

15.8 Lack of such databases has been commented on elsewhere. Kapp notes that the US:

“lacks a comprehensive, large-scale, rigorously collected multi-setting empirical database [and argues that] such a database is solely needed to measure accurately the tangible therapeutic outcomes of the jurisprudential changes of the past several decades. Unfortunately, the construction and maintenance of such a database remains a glaringly unfulfilled research agenda at this point in time and ought to constitute the next major component of the therapeutic justice inquiry” (Kapp, 1994).

Appelbaum described “a cottage industry of empirical studies of commitment” in the US in the 1970s and 1980s and noted that this had not developed elsewhere (Appelbaum, 1997). He suggested that the reason for this was that resources for these policy-orientated investigations are much “more limited” than for other kinds of clinical research. As noted above, Scotland is ideally place to carry out research on a full national population.

LACK OF RESEARCH

15.9 There may be many reasons why there is so little research on mental health law in Scotland. These comments are largely personal and reflect my own (JMA) experience over the last few years and discussions with colleagues. I am assuming that lack of interest is not the only reason.

Funding

15.10 I have had two studies funded by the Scottish Office, both coming from a clinical (rather than legal) perspective. One study was funded by the CSO and the other was funded by CRAG. In both cases it took many months of negotiating with these bodies before they would even consider a research proposal on the impact of mental health law. The initial response of the CSO was the MWC should be carrying out such work. They then suggested that such “monitoring” was audit not research. CRAG did not accept that it was audit. Several months later the CSO agreed to consider a proposal. For the second piece of work it took several months to persuade CRAG that it was ‘their turn’ to consider a second proposal.

15.11 Clarifying where responsibility to consider/fund research on the law lies might be helpful.

Publication

15.12 In our attempts to publish papers from the first piece of research we hit a surprising (to us) response from some journal editors and reviewers. This was that research on Scottish law would not be of interest to many people and was not, therefore, suitable for publication in a journal with an international readership. Since our view would be that many of the issues raised by the research and the points made are generalisable to, or inform, other contexts, this would appear to be short sighted.

The Research Assessment Exercise (RAE)
15.13 The RAE, a four yearly assessment of research in universities relies heavily (or, at the very least, is perceived as relying heavily) on research income and the impact factor of journals in which the research is published. Concern has been expressed that minority areas of interest might be squeezed out under this process. Difficulty in publishing in high-ranking journals might make an area unpopular.

15.14 The recent document on public health in Scotland has pointed to the impact of the RAE on the public health agenda and the need to conduct research “that is generalisable and not just of relevance to the NHS or the local population” (Scottish Executive, 1999). Tomlinson, reviewing the RAE in respect to medical research in general concludes that as well as undervaluing clinical and health services research in general it has especially “disadvantaged highly specialised and multi-disciplined research” and that it “promotes a short-term approach to research” (Tomlinson, 2000).

15.15 Both these points could influence against researching mental health law. This area of research is ideally suited to a multi-disciplinary perspective and funding, and a long-term planned programme. The need for both short and long-term follow up of changes to the law is demonstrated by research in the US which showed an immediate impact which disappeared to revert to previous patterns of use (Appelbaum, 1997).

RECOMMENDATIONS

- the development of a national data base
- a commitment to a programme of research to monitor the new Act
- responsibility for funding such research to be identified
LIST OF ACRONYMS

AMA against medical advice
BPRS Brief Psychiatric Rating Scale
CAL curator ad litem
CCO Community Care Order
CLI Current Legal Information
CPA Care Programme Approach
CPSA Criminal Procedures Scotland Act
CTO Community Treatment Order
DoH Department of Health
ECT Electro-convulsive Therapy
ELOA Extended Leave of Absence
GP General Practitioner
IPCU Intensive Psychiatric Care Unit
IPR independent psychiatric report
LOA Leave of Absence
MATCS MacArthur Treatment Competency Study
Assessment scales used
EC Expressing a Choice
NOD Non-acknowledgement of Disorder
NOT Non-acknowledgement of Treatment potential
POD Perceptions of Disorder
TRAT Thinking Rationally About Treatment
UTD Understanding Treatment Disclosures
MHA Mental Health Act 1983
MHO Mental Health Officer
MHRT Mental Health Review Tribunals
MHSA Mental Health Scotland Act
MWC Mental Welfare Commission for Scotland
NAA National Assistance Act
NHSME National Health Service Management Executive
OPC Outpatient Commitment
PSE Present State Examination
RAE Research Assessment Exercise
RMO Responsible Medical Officer
SWD Social Work Department
REFERENCES


Committee under the Chairmanship of Bruce Millan (1999) Review of the Mental Health (Scotland) Act 1984. First Consultation Paper,


Keenan, T. (1999) To Explore the Predominant Use of Section 24 of the Mental Health (Scotland) Act 1984. Thesis for Master of Community Care, Faculty of Medicine, University of Glasgow.


Special Hospitals Service Authority (1993) Big, black and dangerous? Report of the Committee of Inquiry into the death in Broadmoor Hospital of Orville Blackwood and a review of the deaths of two other Afro-Caribbean patients. London: SHSA


Zusman, J. (1985) APA’s model commitment law and the need for better mental health services. Hospital & Community Psychiatry 36, 978-980