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

Hilary Patrick[[1]](#footnote-1)\*

**Introduction**

This article looks at the Millan Committee’s review of Scottish mental health law, with some

reference to the work of the Richardson Committee[[2]](#footnote-2)1 and the Government’s response to it[[3]](#footnote-3)2. Whilst

the issues raised were similar; the Scottish approach is likely to differ in certain significant respects.

It is hoped that the article will, therefore, add to the debate south of the Border.

**Remit of Millan Committee**

The Millan Committee was appointed in February 1999 to undertake a comprehensive review of

the Mental Health (Scotland) Act 1984. Its chairman is the Rt Hon Bruce Millan, a former

Secretary of State for Scotland and European Commissioner. Members of the Committee include

the usual psychiatrists, nurses, social workers, lawyers and representatives of voluntary

organisations and also, unlike Richardson, user and carer representatives.

The Committee has taken evidence from a wide range of groups and individuals and has carried

out separate consultation processes with users, carers and people with learning disabilities. Like

Richardson, however, our work has been made more difficult by the short time frame within which

we had to operate, just over 18 months for a fundamental review of legislation last reviewed in the

1960s. (It is instructive to note that the Percy Commission[[4]](#footnote-4)3 took four years to reach its

conclusions.)

The Committee will be issuing its final report early in 2001 and this article cannot pre-empt its

conclusions, but it may be instructive to indicate key areas of concern, particularly where the

Committee appears to be diverging from Richardson.

Those key areas are: capacity and the grounds for compulsion, compulsory treatment in the

community, protection for voluntary patients, whether learning disability should be included in

mental health legislation and advance directives.

**Incapacity as a ground for compulsory intervention**

The Mental Health (Scotland) Act 1984, like its English equivalent, sets out a series of tests which

must be satisfied before a person can be admitted to hospital. Unlike England and Wales, before a

long term order can be made, the forum, in this case the sheriff court, has to approve the order.

(Both Richardson and the Government appear to have accepted that the Scottish system is

preferable, for human rights reasons.) A sheriff can make an order only if satisfied that

• The patient has a mental disorder (‘the diagnosis test’)

• The disorder is such that it is appropriate for the patient to be treated as an in-patient in hospital

(‘the appropriateness test’)

• The patient needs treatment in the interests of his or her own health or safety or for the

protection of other persons (‘the risk test’) and

• Such treatment cannot be provided unless compulsory measures are used (‘the justification

test’)[[5]](#footnote-5)4.

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

The Committee’s greatest concern was over the appropriateness test. The other tests contain a

measure of objectivity which can be challenged by a patient opposing an order. The patient can

obtain independent psychiatric reports to challenge the diagnosis test, and can challenge risk

assessments made by the doctors[[6]](#footnote-6)5. Evidence from social workers or others can be obtained which

can demonstrate that there are alternatives to detention in hospital and that the justification test

has not been satisfied.

The appropriateness test is less transparent. Leaving aside its automatic linking of compulsion with

hospitalisation, which may no longer be appropriate if a principle of minimum necessary

intervention is accepted, the test is still flawed. It is based on the doctor’s professional judgement

that hospital care is necessary, without making explicit the grounds on which the doctor is to reach

that decision. All the patient can do is obtain another doctor’s opinion stating that hospital is not

appropriate. As it is the first doctor who will remain responsible for the continuing care of the

patient, the sheriff is likely to give greater weight to her assessment of the patient’s needs.

The appropriateness test met with little approval on our first consultation, and many respondents

urged the Committee to look at a capacity test to replace it. It was argued that lack of capacity was,

in fact, the reason why doctors felt it appropriate to take compulsory measures in particular cases.

Lack of capacity was the ethical justifications for the law’s discrimination against people with

mental disorders. It was the reason why they were singled out from other patients and could, in

certain circumstances, be compelled to receive treatment against their will. A mental disorder can

so incapacitate someone that they lose their own autonomy. Society then has a duty to intervene

to protect the patient. An inevitable corollary of this principle is that so long as the patient does

retain capacity (however impaired) they should be able to take their own decisions, however

unwise, in the same way that non-mentally ill people are able to take unwise and irrational medical

decisions[[7]](#footnote-7)6.

The Committee is still considering the place a capacity test should have in Scots law. There is

concern to deconstruct the basis on which doctors make decisions about whether compulsory

measures are appropriate and a desire to ensure that the new law has a firm ethical base (not least

to comply with ECHR obligations). However there is also concern that lack of capacity may not

be the appropriate test to use when determining whether a person should be subject to compulsory

measures.

Capacity fluctuates. Is it appropriate that a person should be free to discharge himself from

hospital on a day when he is not delusional even if doctors suspect that the next day he will be very

different? Capacity, or lack of it, is very difficult to diagnose. (Delegates at our specialist dementia

seminar explained how fluid a concept capacity was, requiring observation of the patient over a

period of time, with a multi-disciplinary input into the assessment.)

The test in the new Act would have to be functional. A doctor would have to certify that the

patient was unable to take medical decisions relating to her mental disorder, because of the mental

disorder. The fact that a decision was unwise could not, of itself, lead to a conclusion that the

patient lacked capacity; as this would violate the non discrimination principle. Clearly the fact that

the patient was rejecting the help offered might be an indication of his mental disorder. However

concern was expressed that a patient might be held to ‘fail’ the capacity test simply because he or

she disagreed with what the doctors recommended.

Any capacity test would need to be widely interpreted, and would need to include all the so-called

Eastman elements[[8]](#footnote-8)7 (inability to take a decision, to communicate, to understand information, to

understand that one was ill or to make a true choice). However there was concern that there could

still be people who were ill, who needed help and yet who might fail to receive the help they needed

because they ‘passed’ the capacity test. To some of the Committee the capacity test seemed unduly

legalistic, promoting autonomy (or apparent autonomy) at the expense of the equally important

ethical principle of beneficence. Richardson recognised this dilemma and suggested that the

decision as to whether there should be an exception to the general rule in this situation was a

matter for the politicians[[9]](#footnote-9)8. The Millan Committee is likely to go further and attempt to produce

a formula which recognises the ethical attractions of the capacity test but tempers this with a

common sense and pragmatic approach.

We have tried to consider what it is about mental disorder that should justify special treatment

under the law. [While a mental disorder can affect cognition, one of the elements in a capacity test,

its effect is more than that.] Feeling, emotion, judgement, all may be impaired. A person may know

that they are ill but be compelled by their illness to reject treatment (the true choice test).

There was some feeling in the Committee that the criteria for the use of compulsory measures

should be the patient’s impaired judgement rather than his or her lack of capacity.

The distinction between impaired judgement and lack of capacity is subtle, but important.

‘Impaired judgement’, unlike incapacity, is not a legal term of art. If included in a statute, the

words would be given their ordinary meaning. The test says that it should not be possible to take

compulsory measures in the life of a person who has a mental illness, if their decision making

ability in relation to treatments for that illness is unaffected by the illness. But if the illness has

distorted the person’s ability to decide on treatments, the person should be given the benefit of

medical treatment and support. The test is perhaps less legalistic than the incapacity test. It might

be closer to the decisions which psychiatrists actually make on the ground. It might also be less

stigmatising for those who are found to need compulsory measures.

The distinction between incapacity and impaired judgement may be seen more clearly in the light

of some case studies. Impaired judgement (i.e. judgement impaired because of the mental disorder)

would be seen in Richardson’s depressed housewife who thought life was not worth living9, in the

young woman with anorexia who does not accept she is dying and in the delusional patient who

thinks the doctors are trying to poison him or her. While the second two would probably also lack

legal capacity, the first might not. However the person with schizophrenia who knows they are ill

but who wants to try to live drug free would not be caught. The doctors might not agree with their

decision, but if it was made with full understanding of the facts and possible risks, they would have

to respect it. Even if the patient’s decision was unwise, it would not be the mental disorder which

distorted it.

Whether the Millan Committee ultimately decides on a strict capacity test or prefers the impaired

judgement criterion may have little effect in practice on the number of people subject to

compulsory measures under the Scottish legislation. Research in certain US States which

introduced narrow ‘dangerousness’ criteria into their mental health legislation showed that, while

commitment rates dropped immediately after the introduction of the new legislation, they then

rose to previous levels. Commenting on this trend the researcher wrote that

‘When the results of a law narrowly applied will be contrary to the moral intuitions of [those

applying the law] they will act at the margins to modify the law in practice to achieve what seem to

them to be more reasonable outcomes.’[[10]](#footnote-10)10

The Millan Committee’s deliberations are based on this common sense approach: attempting to

find solutions which reflect the innate common sense of those operating the law and those who

may be subject to its provisions, but which also have a firm ethical foundation.

**Compulsory treatment in the community**

Unlike Richardson, Millan’s remit did not include a requirement that it should find a method of

introducing compulsory treatment in the community (CTOs). Hostility to such orders has been

strongly expressed in Scotland by, among others, the Scottish Association for Mental Health

(similar to MIND south of the border) and the Scottish Users’ Network (SUN). However despite

the arguments against CTOs, there are also powerful reasons to suggest that some kinds of

compulsory measure should be available outside a hospital setting.

The Committee has yet to reach a final decision, but is giving serious consideration to removing

the automatic linking of compulsion with hospitalisation. There are several reasons for this.

First, the principle of least restrictive and invasive intervention means that, if a person can be

adequately and appropriately helped without requiring in-patient treatment, this should be

offered. This should not be at the expense of a proper care plan, looking at the person’s needs for

health and social supports, however. Treatment should mean more than just medication and any

care plan should be approved by the forum and subject to review by them. (Some people who are

so ill as to require compulsory measures may, in fact, regard hospital as a less restrictive option.

Any new law should allow their wishes to be respected.)

Secondly, while closure of long stay hospitals has taken place more slowly in Scotland than in

England and Wales, all the trends are in the direction of community based services. To link

compulsion to bricks and mortar rather than to appropriate services might, it was argued, render

a new Act obsolete almost from its inception.

Thirdly, the Committee was made very aware of the conditions in our acute psychiatric wards.

Successive reports from the Scottish Health Advisory Service have highlighted the strains under

which the system is operating. Many of those opposing CTOs (the present author included) did so

on the assumption that patients receiving compulsory care in hospital could be guaranteed a

certain standard of care and support. That assumption can no longer be made. Provided

reciprocity (another principle the Committee is moving towards) is accepted, a patient may receive

a better standard of care in the community, with less disruption to their lives.

The Committee does not, however, believe that community orders on their own will solve the

problems of those patients with whom services find it difficult to engage. Patients may be required

to live in a certain place or to accept forms of medical treatment, but if they are not convinced that

services can help them, they will simply vanish. Assertive outreach and new ways of trying to

engage with patients are needed.

**Informal patients**

Another major concern for the Committee was the protection of voluntary patients, some of

whom told us that they were only in hospital because they had been told that they would be

sectioned if they attempted to leave. How can the law protect these patients?

Some of those coming from a civil rights background would prefer the reluctant voluntary patient

to be made subject to compulsory measures rather than stay in hospital under pressure. The

detained patient can appeal against detention; have their treatment reviewed by a second opinion

doctor and apply the Mental Welfare Commission for discharge. Better to be actually than de facto

detained. On the other hand there was a strong feeling in the Committee that the principle that the

Act should not be used if a patient was willing to be admitted informally[[11]](#footnote-11)11 was equally important.

A patient who is sectioned has less freedom to negotiate with doctors than the so-called ‘voluntary’

patient, (perhaps more accurately described as an ‘informal’ patient) and there may be additional

stigma in having been a detained patient.

Many of those who responded to our consultation said that voluntary patients needed extra

protection. Clearly bullying a patient to stay in hospital or to accept medication is not acceptable.

If a person is truly unwilling to stay, and doctors consider this necessary, formal procedures should

be used. A revised and strengthened Code of Practice should make this clear.

However there is a distinction between bullying and information giving. In certain circumstances,

if an ill patient asked doctors whether they were free to leave, it would be appropriate for them to

be told that, although they were, doctors would use detention measures if they did try to go. It was

hard to see a way of protecting patients against this apparent ‘threat’ so long as compulsion

remains a part of mental health law.

The Law Society of Scotland suggested replacing the concept of medical consent with ‘evident

willingness’ to accept the care or treatment proposed. It regarded consent as too passive, not fully

recognising the patient as a partner in the medical decision making process. ‘Evident willingness’

is the term used in some continental systems and would not, it was felt, include the informal

patient who clearly did not want to be in hospital or to accept the medication proposed.

Whilst some respondents to our consultation felt that specific legal safeguards needed to be put in

place for informal patients, on the whole the feeling of the Committee has been against this. Rather

it seems likely that the Committee will recommend general improvements overall to the Act which

will strengthen the position of informal patients. Rights to advocacy, new principles stressing

participation and respect for the patient’s wishes, improved rights to information and a

strengthened Code of Practice should improve practice and increase the ability of all patients to

participate in their care and treatment.

**Patients with incapacities**

A sub-category of informal patients is those who, as in Bournewood[[12]](#footnote-12)12, are unable to take decisions

about their treatment. Scotland now has its own incapacity legislation to protect such patients.

Under the Adults with Incapacity (Scotland) Act 2000, if a patient is incapable[[13]](#footnote-13)13 of making medical

decisions the doctors can do what is reasonable to promote or safeguard the patient’s physical or

mental health[[14]](#footnote-14)14. The wording clearly includes patients whose mental disorder makes them

incapable of deciding about psychiatric treatment.

In Scottish psychiatric wards in the future there could, therefore, be patients all with similar

diagnoses but with three different legal statuses: informal patients, detained patients and those

being treated under the incapacity legislation.

The new Act does not, however, allow doctors to admit a patient to a psychiatric hospital against

their will[[15]](#footnote-15)15. If a patient lacking capacity appeared unwilling to go to hospital the Mental Health Act

would have to be used. Nor does the Act allow detention[[16]](#footnote-16)16. If a person was de facto detained, as

some of their Lordships thought the patient in Bournewood was, the Mental Health Act should

be used.

There has been some debate in Scotland about proposed new rules for medical treatment for

mental disorder for patients with incapacities. New regulations will spell out the safeguards to be

imposed for special treatments which fall outside the doctors’ general authority to treat. It is

thought, for example, that Court of Session approval will be required for non-therapeutic

sterilisation of a mentally incapable woman (despite the fact that all other decisions about patients

are to be taken by the lower, sheriff courts). More controversially, the Scottish Executive appears

to be accepting the recommendations of a working group[[17]](#footnote-17)17 to extend psychosurgery to patients

who are unable to agree to it, provided the need for the operation is confirmed by the Court of

Session. (The working party argued that those patients most in need of this rare procedure might

be the very ones least able to accept it, such as patients with depression so disabling that they

lacked the legal capacity to take medical decisions on their own behalf.)

For the majority of patients, however, the argument is about the special treatments currently set

out in s98 of the Mental Health (Scotland) Act, long term drug treatment and ECT. Many of those

responding to the consultation argued that the protections for incapable patients should mirror

those in the Mental Health (Scotland) Act for detained patients. ECT at any time and drug

treatment for over three months should require approval by a second opinion psychiatrist

appointed by the Mental Welfare Commission. Protection against inappropriate treatment is

vitally important for the person with incapacities, who may even lack the capacity to complain

about treatment received.

While the Scottish Executive appears to have accepted the argument in respect of ECT, there

appears an unwillingness to extend the rules on long term drug treatments to those with mental

incapacities. This appears to be on resource grounds. Many residents of nursing homes currently

receive drugs for mental disorder prescribed by GPs and obtaining psychiatric approval of this

prescribing would, it is felt, place too great a burden on already stretched services.

Yet evidence has indicated that the problem with medication prescribed to nursing home residents

is not merely theoretical. An important study in Glasgow looked at nursing home residents in the

south of the city and found that 24% of them were being prescribed the major neuroleptic drugs,

and in 88% of these cases the researchers did not regard the drug as clinically appropriate[[18]](#footnote-18)18.

The Scottish Executive is waiting to publish its regulations until it receives the Millan Committee’s

report. The Millan Committee is considering whether mental health and incapacity legislation

should be consolidated into one act. If it does, there are powerful arguments for requiring that the

safeguards for special treatments should be the same for incapable patients as for those subject to

compulsory measures.

**People with learning disabilities**

As in England and Wales, the Scottish Mental Health Act includes in its remit people with learning

disabilities, even though on the whole they are not ill and their disability cannot be ‘cured’. There

were powerful arguments on both sides about whether people with learning disabilities who were

not otherwise mentally ill should be included within a mental health act. Currently about 170

people with learning disabilities in Scotland are detained under the Act, some because they are

suffering from a mental illness but the majority because of ‘abnormally aggressive or seriously

irresponsible behaviour’[[19]](#footnote-19)19.

The Committee took evidence from New Zealand (unfortunately via a video link) which several

years ago took learning disability out of its Mental Health Act. The result was that a significant

number of people were discharged from hospital and no suitable accommodation was provided for

them. Following the inevitable disruption, New Zealand is now introducing new legislation for

people with learning disabilities, which will include the use of compulsory powers.

However the Committee heard pressing arguments for excluding learning disability from the

legislation. It is not a mental illness and not, generally a medical problem at all. It is only included

in the current act as an add-on to an act mainly dealing with the effects of serious mental illness.

Only one provision was widely welcomed, that which imposes an unequivocal duty on local

authorities to provide free day training and occupation for people with learning disabilities living

in the community[[20]](#footnote-20)20.

Whether learning disability remains in the Act or whether Millan recommends a fundamental

review of the law following the Scottish Executive’s new strategy for people with learning

disabilities[[21]](#footnote-21)21, it is no longer acceptable for people with learning disabilities to be included in mental

health legislation almost by default. The Act should be examined afresh to see what provisions are

relevant to them and what are not. Discrete provisisons incorporating rights to services, protection

of vulnerable people and secure provision for those who might pose a risk to others, should be put

in place.

**Advance Directives**

A major area of discussion was advance directives. When the Adults with Incapacity Bill was

placed before the Scottish Parliament, the Scottish Executive found itself unable to take on the

recommendations of the Scottish Law Commission in its Report on Incapable Adults[[22]](#footnote-22)22 that

advance directives in health care be given legal force. The inevitable backlash from the Catholic

Church and pro-life groups was one which the new Executive felt itself unable at that stage to

withstand.

The Millan Committee will not seek to reopen that discussion, but it is considering the role of

advance directives in psychiatric care. This is particularly relevant in the light of its likely

recommendation that a new Act stresses the importance of patient participation in care decisions

and respect for patients’ wishes.

Advance directives in psychiatry can take several forms. A patient may fill out a ‘crisis card’ naming

people to contact in an emergency. The card may direct doctors to discuss the patient’s care with

the named person and may also specify types of treatment that the patient does or does not want.

A patient may sign a ‘contract’ with their consultant setting out the terms of their discharge from

hospital and the sort of conditions which might result in the patient being recalled. The contract

might spell out the patient’s preferences about future treatment. A patient might appoint another

person her ‘health care proxy’ to take medical decisions on her behalf[[23]](#footnote-23)23. Alternatively a person may

go to their lawyer and sign a formal document along the lines of a ‘living will’ stating their

treatment options in the event of future incapacity[[24]](#footnote-24)24.

Many commentators think that even if advance directives are not legislated on, they are already

legally binding. The BMA has given advice to doctors saying that doctors should recognise them[[25]](#footnote-25)25.

However an advance directive can be overruled if the patient is detained under the Mental Health

Act. Doctors might take a directive into account when considering treatment options, but would

be under no legal duty to do so.

Clearly from the patient’s point of view, advance directives represent a way of reducing uncertainty

about the future and of giving the patient more control over their lives. If drawn up in partnership

with their doctor, they can represent a way of negotiating treatment options. Advance directives

can reduce the powerlessness many patients feel when faced with the psychiatric system. They are

a way of promoting patient autonomy.

From the doctor’s point of view they can reduce the need for compulsion by persuading patients

to agree the type of symptoms which might necessitate their readmission. Doctors are supposed to

try to consider patient preference when deciding on treatment and the advance directive can help

here. It has been shown that compliance with treatment is improved if patients understand the

need for treatment and feel their views are listened to and respected.

Most of the respondents to the consultation appreciated these advantages, and most saw a place

for advance directives in psychiatry. The dividing line was, perhaps predictably, over the legal

effects of directives. While health care providers generally felt they should be persuasive only,

social services and voluntary groups felt they should be legally binding.

Some respondents believed that a directive should be capable of being overruled if there was a

serious risk to the patient’s health or safety. Others (including some GPs and psychiatrists) felt that

a properly drawn up advance directive, made by a patient who was well and in full possession of

the facts, should be respected, even if the result was the patient’s death. These respondents argued

that the principle of non-discrimination (which means that generally the law should discriminate

against mental health service users no more than strictly necessary) demanded no less. If a

Jehovah’s Witness is allowed to refuse a blood transfusion which could save his life, a mental health

service user should be allowed make an advance refusal of treatment and to stipulate that this

should apply even in life-threatening circumstances.

Whether the Millan Committee will accept this principled approach or will adopt a more

pragmatic (and it could be argued compassionate) approach, the author will leave readers of this

article to surmise.

**Conclusion**

Many of the discussions of the Millan Committee (on informal patients, learning disability and

community treatment orders) mirrored those in England and Wales. The Scots were given longer

to carry out their review and were, perhaps, therefore able to carry out a slightly more leisurely and

comprehensive consultation process.

Incapacity legislation was passed in Scotland during the life of the Committee, and the Committee

had to grapple with the complex issues of its interface with mental health legislation.

Unlike Richardson, the Committee’s hands were not tied over the issue of community orders.

If Millan does, in fact, recommend such an order, the Committee’s final report may make

interesting reading for those still involved in the debate.

1. \* Solicitor, Member of the Millan Committee, Honorary Fellow in the Faculty of Law, University of Edinburgh. [↑](#footnote-ref-1)
2. 1 The expert committee chaired by Professor Genevra Richardson whose Review of the Mental Health Act 1983 (‘the Richardson Report’) was published in November 1999 . [↑](#footnote-ref-2)
3. 2 Reform of the Mental Health Act 1983- Proposals for Consultation (1999) The Stationery Office [↑](#footnote-ref-3)
4. 3 The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, whose report [(1957; Lord Percy) Cmnd 169, HMSO, London] led to the 1959 Mental Health Act for England and Wales and the 1960 Act in Scotland. [↑](#footnote-ref-4)
5. 4 Mental Health (Scotland) Act 1984, s17(1). [↑](#footnote-ref-5)
6. 5 Although work needs to be done in making risk assessments more transparent and improving the quality of evidence brought before the sheriff - often no more than hearsay. [↑](#footnote-ref-6)
7. 6 See Sidaway v Governors of Bethlem Royal Hospital [1985] AAC 871 per Lord Templeman. A patient who has capacity is entitled to reject the doctor’s advice ‘for reasons which are rational or irrational, or for no reason’. [↑](#footnote-ref-7)
8. 7 As discussed in Re C (Mental Patient: Medical Treatment) (1993) 15 BMLR 77. [↑](#footnote-ref-8)
9. 8 Richardson Report, paras 2.10 and 7.23. [↑](#footnote-ref-9)
10. 10Applebaum, PS (1997) Almost a revolution: an international perspective on the law of involuntary commitment Journal of the American Academy of Psychiatry and the Law 25, 135-147. [↑](#footnote-ref-10)
11. 11 A principle emphasised by the Percy Commission and found in s17 (2) of the 1984 Act. [↑](#footnote-ref-11)
12. 12 R v Bournewood Community and Mental Health NHS Trust, ex parte L [1998] 3 AER 289. [↑](#footnote-ref-12)
13. 13 A person is ‘incapable’ if he or she is incapable of acting, making or communicating decisions or of retaining the

memory of decisions because of mental disorder. (Adults with Incapacity (Scotland) Act 2000, s1 (6).) [↑](#footnote-ref-13)
14. 14 Ibid, s47(2). [↑](#footnote-ref-14)
15. 15 Ibid, s47 (7) (c). [↑](#footnote-ref-15)
16. 16 Ibid, s47 (7) (a). [↑](#footnote-ref-16)
17. 17 CRAG Working Group on Mental Illness Neurosurgery for mental disorder. The Scottish Office July 1996. [↑](#footnote-ref-17)
18. 18 A McGrath, G Jackson (1996) Survey of neuroleptic prescribing in residents of nursing homes in Glasgow BMJ, 312, 611-612. [↑](#footnote-ref-18)
19. 19 Mental Health (Scotland) Act 1984, s17 (1)(a)(ii). [↑](#footnote-ref-19)
20. 20 Mental Health (Scotland) Act 1984, s11. [↑](#footnote-ref-20)
21. 21 The same as you? A review of services for people with learning disabilities The Scottish Executive June 2000. [↑](#footnote-ref-21)
22. 22 Scot Law Com No 151, September 1995. [↑](#footnote-ref-22)
23. 23 A limited form of health care proxy is incorporated in the Adults with Incapacity (Scotland) Act. (See ss 16 and 50(6).) The proxy’s decisions can be overruled if the doctor obtains a second medical opinion. [↑](#footnote-ref-23)
24. 24 A comprehensive (yet strangely intimidating) model is available from the Bazelon Center for Mental Health Law at www.bazelon.org/advdir.html. [↑](#footnote-ref-24)
25. 25 Advance statements about medical treatment The British Medical Association 1995. [↑](#footnote-ref-25)