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The *Mental Health (Amendment) (Scotland) Bill*: Finances of Incapable Adults

Bill 14 of 1998-99

This paper aims to provide some background to Eric Clarke's Private Member's Bill, which is due to have its second reading debate in the Commons on Friday 12 March 1999. The Bill is intended to make a small amendment to the current legislative arrangements in Scotland for dealing with the funds of incapable adults who leave psychiatric hospitals to be cared for in the community. As the Bill had not been printed at the time of this paper going to press, the comments are based on a draft version of the Bill.

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Summary of main points

The impetus for the *Mental Health (Amendment) (Scotland) Bill* arises out of the fundamental shift in policy for caring for incapacitated patients, from in-patient hospital care to an emphasis on care in the community. Existing arrangements for dealing with the finances of incapable adults in Scotland are considered unsatisfactory where an mentally incapable patient is discharged from hospital into community care. The present Bill aims to provide an interim solution, pending wholesale reform in this area, by allowing hospital managers to continue to hold and expend funds on behalf of incapable patients once they have left hospital.

This paper looks at the shift from institutional to community care, and the existing mechanisms for managing the financial affairs of incapable adults, before discussing the Bill itself and setting it in the wider context of the reforms proposed by the Scottish Law Commission. The major review of the whole of the *Mental Health (Scotland) Act 1984* is also referred to.The government's position on these reforms is that any large-scale legislation in this area should be a matter for the Scottish Parliament; however, it is supportive of the present Bill.

Terminology

The paper will use the terms 'mentally incapacitated' or 'mentally incapable', to refer to a person who is suffering from mental disorder as a result of mental illness, mental handicap, senile dementia or accident. However, some older legislation and materials use other terms which are less acceptable today. A mentally incapacitated person whom the Court considers incapable of managing his affairs is referred to as the 'ward' or the 'incapax'. Where his affairs are being managed by the hospital, rather than by a curator, tutor or judicial factor, the term 'patient' will be used.

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I The shift from institutional to community care

The need for the *Mental Health (Amendment) (Scotland) Bill* arises out of the fundamental shift in policy from caring for incapacitated patients in hospitals to the community. Although "care in the community" is generally associated with the funding changes brought in by the *National Health Service and Community Care Act 1990*, the principle that, where possible, care for people with mental health problems or learning disabilities should be provided in the community rather than institutions dates back forty years. An improvement in the balance between in-patient and community services, for example, was recommended by the "Dunlop Committee", set up by the Scottish Department of Health, as early as 1959.[1] However, by 1985, a report published by the Scottish Office, *Mental health in focus: report on the mental health services for adults in Scotland*, stated that:

> There is at present such a serious shortfall, in Scotland, of community alternatives to in-patient mental health care, that it has not proved possible to develop the comprehensive locally-based mental health service which is required if care in the community is to become a reality. This shortfall can be remedied only if the necessary initial resources are forthcoming. At the same time, in-patient care is provided in psychiatric hospitals, which will need additional resources, both capital and revenue, if they are to be able to adapt to the new role envisaged for them in this report. [2]

As the above quotation makes clear, one of the central problems in building appropriate community-based services is that of resources: ensuring both that there are sufficient funds to keep essential in-patient services running at an acceptable standard (bearing in mind that if institutions are reduced in size rather than closed down altogether, a great deal of capital and revenue will still be tied up in those buildings) and developing appropriate new services in the community.

The extent to which services have moved from institutions to the community, and the financial mechanisms used to achieve this have been considered twice by the Scottish Affairs Committee, resulting in the reports, *Closure of psychiatric hospitals in Scotland* [3] in June 1995 and *The implementation of community care in Scotland* [4] in March 1997. The Committee's earlier report suggested that there was a "lengthy period of apparently contradictory messages" from the Scottish Office as to the importance of resettling residents of long-stay institutions, but that clear guidance was finally issued in 1993: 600 discharges were expected a year, with 8,000 new community places created by the year 2000.[5]

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1 Department of Health for Scotland, *Second Report by a committee on mental health legislation*, 1959

2 Scottish Home and Health Department, *Mental health in focus: report on the mental health services for adults in Scotland*, 1985, pp 16-17

3 Scottish Affairs Committee, *Closure of psychiatric hospitals in Scotland*, 8 June 1995, HC 495 1994-95

4 Scottish Affairs Committee, *The implementation of community care in Scotland*, 18 March 1997, HC 35 1996-97

5 Scottish Office circular NHS MEL(1993)67

However, because of problems defining "community places", the Committee were not able to establish how well this target was being met. Indications of the shift can, however, be seen in the latest Scottish Office statistical bulletin *Community Care 1997*[6] which showed an increase in people with mental health problems attending day centres from 110 in 1983 to 1,695 in 1997 and a decrease in the number of people living in hospitals from 14,693 in 1983 to 10,216 in 1996. The figures for people with learning disabilities show a similar pattern: a decrease in people living in hospitals from 6,052 in 1983 to 3,218 in 1996 and an increase in people attending day centres from 5,427 in 1983 to 8,054 in 1997.[7]

The Committee expressed a number of concerns about the resettlement programme, emphasising in particular the need to categorise beds more helpfully: while the policy of care in the community by its nature implies a reduction in long-stay beds, the need for acute beds (that is, for the use of people in need of urgent treatment) may not decrease. Indeed, it may even increase, as people who in the past would have been permanent residents of a long-stay hospital live mainly in the community but need occasional hospital admission if their health deteriorates. Concerns were expressed as to the danger of patients being discharged before adequate community services were available, especially where there was great pressure on the remaining beds, with occupancy levels of over 100% being reported in major cities.

The Committee identified four forms of financial support for community care which aimed to achieve this funding shift: bridging finance, resource transfers, the Mental Illness Specific Grant and DSS transfer money. The importance of these mechanisms was emphasised in the second report, where the Committee commented that "the one common thread running through all the evidence we received was that resourcing questions lay at the heart of any evaluation of the success of community care."[8] Bridging finance refers to additional funding provided by the Scottish Office to enable local authorities to develop community based services *before* hospital beds are closed; resource transfer refers to a more permanent transfer of financial resources from the NHS to local authorities where responsibility for a particular group of patients is likewise transferred from the NHS to local authorities; the Mental Illness Specific Grant was introduced in 1991, with the aim of assisting local authorities to provide facilities which would both prevent the need for admission to hospital and support those leaving long-stay institutions; and the DSS transfer is the transfer of funding for residential care which would have been provided through Income Support before the responsibility for arranging this care passed to local authorities in 1993 as a result of the *National Health Service and Community Care Act 1990.*

While all four mechanisms will clearly assist in the development of community-based services, a number of concerns as to their practical implementation have arisen. Complaints were made to the Committee in its first enquiry that the amounts of bridging finance were

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6 Scottish Office, *Statistical bulletin: social work series*, SWK/CMC/1998/8, table 4.1

7 *ibid*, table 3.1

8 HC 35-1 1996-97, v, para 3

not always sufficient, or available at the right time.[9] In its more recent enquiry, criticisms were made by witnesses that the allocation process appeared to be "arbitrary and inconsistent" and that the Scottish Office had specific priorities for hospital closure (with the knock-on need for bridging finance in particular areas) but had not made these public.[10] On resource transfers, concerns were expressed to the Committee's earlier enquiry about the lack of transparency accompanying these transfers on the NHS side and, consequently, the possibility of funds "seeping" from the system.[11] In its later report, the Committee highlighted the Accounts Commission view that resource transfer was becoming "a very useful mechanism" (now reaching £90 million a year[12]), but emphasised the need to ensure that best practice as far as transparency was concerned was achieved all over Scotland.[13]

The Mental Illness Specific Grant or MISG rose from £3 million in 1991/92 to £18 million in 1995/96. It was then frozen at £18 million and decisions as to its continuation were made on a yearly basis which caused some anxiety. In its 1994-95 report, the Committee recommended that it should be retained as a long-term commitment in order to nurture the "fragile toehold" established by the first few years of the grant. In its response to the Committee, the previous Government stated its policy that local authorities should be as "unfettered" as possible and that specific grants, by their very nature, limited freedom of action. However, it went on to say that "in determining the future of the grant, full recognition will be given to the need to ensure services are available to assist mentally ill people to live in the community."[14] In the 1996-97 Report, the Committee recommended again that the grant should be retained in the form of a ring-fenced grant but as an integral part of community care funding and with protection for inflation. In July 1998, the Scottish Secretary, Donald Dewar stated that MISG "will continue to provide ring-fenced resources totalling £18 million a year towards community-based mental health projects in Scotland".[15]

Finally, concerns were expressed to the Committee's earlier enquiry that the Scottish share of the transfer of DSS money to local authorities (set at 8.6%) was too low and should be increased to around 10%.[16] It has since been accepted that Scotland receives its fair share, but in its 1996-97 Report, the Committee suggested further work should be done on the distribution formula *within* Scotland.[17]

Despite this emphasis on the transfer of funding between institutional and community care, the Accounts Commission in January 1998 reported that 80% of the £214 million adult[18]

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9 HC 495-II 1994-95, Q121, p 18
10 HC 35-I 1996-97, xii-xiii, paras 24 & 25
11 HC 495-I 1994-95, xiv, para 37
12 HC Deb 29 July 1998 c 292W
13 HC 35-I 1996-97, ix, para 15
14 Scottish Affairs Committee, *Government observations on the third report from the Committee (Session 1994-95) on closure of psychiatric hospitals in Scotland,* HC 42 1995-96, ix
15 HC Deb 29 July 1998 c 291W
16 HC 495-II 1994-95, Q154, p 23
17 HC 35-I 1996-97, vi, para 5
18 this does not include services for people over 65 which are classified separately

mental health budget in the NHS in Scotland is still spent on in-patient care, with a further 5% spent on out-patient service.[19] 8% is then spent on day care services, and an estimated 7% on "community teams" (though the Accounts Commission emphasised that the way that the data are collected for spending on community teams made it impossible accurately to disaggregate the amounts spent on adults aged 16-65 from that spent on children's and over-65s' services). This figure does not, of course, cover spending by local authorities on housing and social services for people with mental health problems, but it does suggest that only a relatively small amount of the NHS budget is being devoted to community care, even though good clinical support in the community may be as central to the success of community care as adequate housing and social support.

The Commission's report also highlighted great variations between NHS trusts in the kind of clinical community services which are available: only a third of trusts provide out-of-hours services, for example, even though the availability of crisis services may be crucial if certain groups of patients are to live successfully in the community. Similarly, the Commission highlighted considerable disparity across Scotland in the proportion of psychiatric nurses working in the community rather than in hospitals. These themes come out clearly in the Accounts Commission's companion report on the views of users and carers: key issues which arose from the Commission's focus groups were the need for help at a time of crisis (including short stay crisis centres providing a place of safety and support), access to out-of-hours services and improved availability and quality of community services.[20]

The Accounts Commission report relates only to the services provided by the *NHS* in Scotland. Some information about other services essential for successful community care, such as supported housing, is found in a report published by the Scottish Association of Mental Health (SAMH) in 1997.[21] According to this report, data from a Scottish Homes database at the time of writing showed that there were 1014 places in supported accommodation for people with mental health problems, only 8% of the number SAMH estimate as necessary. The majority of these places were in shared or communal accommodation, with only a third being self-contained. SAMH suggests that these figures demonstrate a shortfall of almost 12,000 supported housing places, and highlights also the geographical variation in services within Scotland.

Since the publication of the SAMH report, the Scottish Office has fulfilled a commitment made in response to the first Scottish Affairs Select Committee report on psychiatric hospitals, and produced a substantial guidance document, *Framework for mental health*

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19 Accounts Commission for Scotland, *Adult mental health services: patterns of NHS service provision*, Bulletin 1, January 1998

20 Accounts Commission for Scotland, *Adult mental health services: focussing on the views of users and carers*, Bulletin 2, January 1998

21 SAMH, *Piecing together the jigsaw: progress towards the development of community mental health services*, 1997

services in Scotland.[22] The circular issued with the document emphasises that it does not create new policy; rather it aims to promote the implementation of existing policies by generating consensus over key issues, providing a "template" of services, and establishing a yardstick by which the Scottish Office (in future the Scottish Parliament) can assess local action plans and monitor progress. "Core services elements" are listed as:

- information and access to services
- individual planning of services
- services to promote personal well-being and social development
- services for ordinary living and long-term support
- services offering psychological therapies, including clinical psychology
- services offering physical methods of treatment

The circular also announced a new Mental Health Development Fund of £3 million per year over three years, to provide "pump-priming" funds for community-focussed services for people with mental health problems.

[22] Scottish Office, *A Framework for mental health services in Scotland*, September 1997, issued with circular NHS MEL(1997)62

II Finances of incapable adults

There is a variety of ways in which the finances of a mentally incapable adult can be managed in Scotland. Indeed, the fragmented and archaic nature of these mechanisms and the fact that they can fail to provide an adequate remedy in many common situations has prompted calls for a wholesale reform of the law in this area. A particular criticism has been that the present framework inhibits the movement of incapable adults from hospitals to the community. The reforms proposed by the Scottish Law Commission, and the responses of this and the previous government, are outlined below [see Part IV].

The management of a mentally incapacitated person's affairs is usually separate from management of their personal welfare, with different kinds of manager generally having powers relating to only one or other of these aspects. The types of management described below (with the exception, in theory, of tutors) relate only to financial management.

The Mental Welfare Commission for Scotland [MWC] plays a major role in protecting the persons and interests of mentally incapable adults, whether in hospital or other institutions or in the community. In relation to financial affairs, the MWC must enquire into any case where it appears to them that such a person's property may be exposed to loss or damage. It must also notify any hospital or local authority when it considers that they should exercise their functions in order to prevent or redress loss or damage to property. In addition the MWC has various duties to visit patients who are detained in hospital.[23]

It was estimated in 1997 that there are up to 100,000 people in the population at any one time who are incapax, and that this number is likely to grow rather than decline as life expectancy outstrips the ability of medical science to prevent or cure the various forms of age-related mental deterioration.[24]

A. Hospital management

Hospital patients who are liable to be detained under the *Mental Health (Scotland) Act 1984*, or who are receiving treatment for mental disorder, can have their funds administered by the managers of the hospital under section 94 of the *Mental Health (Scotland) Act 1984*.[25] There is no equivalent legislation to authorise the managers of other care establishments to manage the finances and property of incapable residents. Recent investigations by the MWC suggest that the majority of incapax patients whose funds are managed by their hospital are suffering from chronic schizophrenia, learning

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23 *Mental Health (Scotland) Act 1984* section 3

24 Scottish Office consultation paper, *Managing the Finances and Welfare of Incapable Adults*, February 1997

25 This procedure pre-dated the *1984 Act*, which was mainly a consolidation statute.

disability or dementia, and have usually been in hospital for a number of years with the majority not having contact with relatives.[26]

All that is required for the hospital to take over management of a patient's funds is for the responsible medical officer to state that, in his opinion, the patient is incapable of managing and administering his property and affairs, by reason of his mental disorder. However, if the patient has funds of more than £5,000[27] the consent of the MWC is required before the hospital managers can take up these powers. If the funds exceed £50,000, the Commission will normally consider the appointment of a curator bonis [see below] to be more appropriate, as it may also be in certain circumstances where the funds are between £5,000 and £50,000. A hospital which is managing a patient's finances must now also seek the consent of the MWC in order to spend in excess of 1.5% of the patient's capital in any year.[28] Recently the MWC has started asking NHS Trusts and hospitals to complete twice yearly returns on all their incapax patients, as well as auditors' certificates on the management of incapax patients' funds.[29]

Hospital management has been described as:

> a relatively quick and inexpensive method of administering funds and possessions of a modest value. It avoids the cumbersomeness of accounting to, and supervision by, the Accountant of the Court. It does not impair any existing legal capacity.[30]

The powers available to hospital managers under section 94 are limited to receiving and holding money and valuables, and expending them for the patient's benefit. They must have regard to any sentimental value that an article may have for the patient (or would have but for his mental disorder),[31] but no further statutory guidance is given as to how these powers should be exercised.

There have been some concerns that staff feel that to spend money on certain patients would be to waste it, and consequently that no great effort should be made to ensure that all income available to the patient is claimed, or that any money received should simply be preserved instead of being used to enhance the quality of his life.[32] On the other hand, it appears that in some cases the money was being used to purchase goods or services

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26 Mental Welfare Commission for Scotland *Annual Report 1997-98*, 5 November 1998, p16

27 This figure is set by the Secretary of State and increased from time to time. It was raised to the present amount in January 1993

28 Mental Welfare Commission for Scotland *Annual Report 1992-93*

29 Mental Welfare Commission for Scotland *Annual Report 1997-98*, 5 November 1998, p15

30 Adrian D. Ward, *The Power to Act*, 1990 p112

31 section 94(3)

32 Scottish Home and Health Department, *Report of the Working Party on Incapax Patients' Funds ('the Crosby Report')*, 1985, S.O.P. Scottish Office N.S. 12, paras 18-23

which would normally be provided by the NHS.[33] The *Crosby Report* in 1985 made various recommendations as to how hospital staff should exercise their discretion in accumulating and spending patients' funds.[34]

Other criticisms of the scheme were mentioned in the Scottish Law Commission's Discussion Paper on managing the welfare and finances of incapable adults:

- Only one medical certificate is required to bring a patient's funds under hospital management;
- There is no opportunity to challenge the certificate;
- There is no consideration of the evidence in a hearing (the Discussion Paper suggested that this may mean the procedure is in breach of the *European Convention on Human Rights*);
- Management by hospital central management may be regarded as remote and impersonal;
- There is no individual appointed with specific responsibility for the funds of particular patients;
- It is not clear whether the duty to receive money extends to withdrawing money from a patient's bank or building society account in order to spend it on the patient's welfare;
- The current limit of £50,000 could seem excessive considering that mentally incapable people with estates this size living outside hospitals would almost certainly have curators appointed.[35]

The Scottish Office issued draft guidance for consultation last summer on the management of the finances of incapable adults, pending wholesale legislation along the lines proposed by the Scottish Law Commission.[36] It is addressed to Health Boards, local authorities and relevant independent sector agencies and is intended to build on the recommendations of the Crosby report and good practice since then. The draft guidance states that all the relevant bodies should draw up policies for the management of incapax patients' funds and ensure that these are understood and applied by all staff. It goes on to suggest a number of procedures and practices which should be adopted. The closing date for receipt of responses was 31 October 1998, but there is no fixed date yet for the publication of the guidance in its final form.

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33 *ibid* paras 24-29, and the Mental Welfare Commission for Scotland *Annual Report 1997-98*, 5 November 1998, p15

34 Scottish Home and Health Department, *Report of the Working Party on Incapax Patients' Funds ('the Crosby Report')*, 1985, S.O.P. Scottish Office N.S. 12

35 Scottish Law Commission Discussion Paper 94, *Mentally Disabled Adults: Legal Arrangements for Managing their Welfare and Finances*, September 1991 paras 4.20 and 4.154 to 4.161

36 Scottish Office draft circular, *Protection of the finances and other property of people incapable of managing their own affairs*, 31 July 1998

The powers given by section 94 do not exclude hospital managers from operating other management techniques set out below, such as being appointed to receive DSS benefits, although it has been suggested that it is incompetent for hospitals to act as negotiorum gestors.[37]

Hospital management is terminated by appointment of a curator bonis, judicial factor, or tutor, but the *1984 Act* does not contain any specific procedures for termination even where, for instance, the patient retains capacity or where there have been shown to be serious deficiencies in management. Ashton and Ward suggest that in such circumstances it would probably be appropriate to apply for a declarator, or for judicial review.[38]

B. Curators bonis, judicial factors and tutors

A curator bonis can be appointed to manage the assets and affairs of a person over 16 who lacks the capacity to manage his own financial affairs. This is the most widely-used general legal procedure for managing the funds of a mentally incapacitated person.[39] Indeed, curatory (the appointment of a curator) can be the default mechanism as the MWC may, and the local authority must, apply to the court to appoint a curator if no-one else is doing so and a curator ought to be appointed.[40] A curator is a specific type of judicial factor, which is the general term for a person appointed by the court to do something on behalf of another person.

Applications are to the Court of Session or Sheriff Court, and must be supported by two medical certificates stating that the person is 'of unsound mind'. The incapacitated person and his relatives are entitled to oppose the petition.

Curators are under the supervision of the Accountant of the Court, to whom they must submit annual accounts for audit. They may be remunerated, and they are usually professional people such as solicitors.[41] Upon appointment a curator automatically supersedes hospital management, DSS appointees and most other managers under specific statutory provisions. However, a curator is in turn superseded by the appointment of a tutor-at-law.

Curatories can be expensive, as the funds of the ward must cover the court petition to appoint the curator, the curator's ongoing remuneration (which is determined annually by the Accountant of Court on a percentage basis with the aid of tables), annual audit costs

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37 Gordon Ashton and Adrian Ward, *Mental Handicap and the Law*, 1992, p606

38 Gordon Ashton and Adrian Ward, *Mental Handicap and the Law*, 1992, p606

39 In 1991 a figure of 400 was quoted for the number of appointments per year - Scottish Law Commission Discussion Paper 94, *Mentally Disabled Adults: Legal Arrangements for Managing their Welfare and Finances*, September 1991 para 4.2

40 *Mental Health (Scotland) Act 1984* ss 92 and 93

41 see Fiona M Rutherdale, *Financial Management of Mentally Incapacitated Adults: Characteristics of Curatories*, Scottish Office Central Research Unit, 1992, S.O.P. Scottish Office N.S. 14

and the costs of any further court applications to authorise particular actions by the curator. Adrian Ward has suggested that

> it is now accepted that curatories are uneconomic for estates less than about £50,000 […] what happens in practice is that if a curator is appointed, then the costs of the curatory eat up the funds until nothing is left. In other words, the mentally handicapped person is deprived of his funds and assets by the system designed to protect them. Cases where this is happening are coming to light with depressing regularity. They often occur as a result of deinstitutionalisation.[42]

A study published in 1992 found that the lower the ward's annual income the higher the percentage of income taken up by the annual administration cost, and that in some cases this could amount to 80% of the income.[43] However, only 4% of all curatories studied were terminated because the capital of the ward's estate had been exhausted.[44]

A curator takes over the ward's entire estate, and appointment therefore results in the ward's complete loss of legal capacity to manage. Even if a curator was appointed because there were matters of particular complexity to be dealt with, the ward loses legal capacity in relation to management of simple matters of which he may in fact be capable.

However, if it is necessary to appoint someone to administer a particular fund or asset, there are several other specific types of judicial factor who can be appointed, under similar terms and conditions to curators bonis. The ward will not then necessarily be deprived of all legal capacity.

Tutors-dative and tutors-at-law are the two other types of financial guardian which are appointed by the courts. Either can in theory be both personal guardians and financial managers, and the former can be appointed with either general or limited powers. Only the nearest male relative on the father's side can be appointed tutor-at-law; none were appointed for over 100 years until 1995. Appointment and duties of tutors are similar to those for curators bonis, but their functions are not altogether clear as most of the relevant law is very old.[45]

C. DSS appointees

The *Social Security (Claims and Benefits) Regulations 1987* [SI 1987/1968] authorise the appointment of someone to apply for, receive and deal with benefits on behalf of a person unable for the time being to manage his own affairs, where no tutor or curator has been

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42 Adrian D. Ward, *The Power to Act*, 1990 p 92

43 Fiona M Rutherdale, *Financial Management of Mentally Incapacitated Adults: Characteristics of Curatories*, Scottish Office Central Research Unit, 1992, S.O.P. Scottish Office N.S. 14, para 4.12

44 *ibid* para 5.5

45 Tutors-at-law are appointed under the *Curators Act 1585*, and the functions of tutors-dative are set out in cases from the 17th and 18th centuries when such appointments were common.

appointed. There are no financial limits, and any person over 18 may apply by completing the appropriate form. Monitoring of this power is limited.[46]

Various other pieces of legislation contain provisions for the management of particular types of assets or single acts of management on behalf of people lacking management capacity.

D. Trusts

Funds can be held by trustees under a formal trust for the benefit of a mentally incapable person. The terms and conditions under which the trustees hold and administer funds and assets are set out in the provisions of the trust deed and in the general law of trusts. Trusts are generally less expensive to run than curatories. However, once incapacitated, a person cannot hand over his own funds to a trust even if it is for his own benefit.

E. Negotiorum gestio

Negotiorum gestio is the legal term for the position where someone informally undertakes the management of the affairs of a person who is absent or lacks capacity, without that person's knowledge although in circumstances where it is reasonable to assume that the person would have given authority if able to do so. This technique can be used to deal with the financial affairs of an incapable adult, but its informality means that negotiorum gestor has no documentary evidence of his authority, nor are there any specific controls or supervision. The rules governing what a negotiorum gestor can and cannot do are set out in case law, most of which dates from the nineteenth century. Negotiorum gestio is not limited to urgent or immediately necessary acts of administration - indeed, in many of the reported cases the administration by the negotiorum gestor has continued for many years.[47]

F. Attorneys

The appointment of an attorney is only valid if the appointer has sufficient capacity at the time; but appointments made on or after 1 January 1991 remain valid even if the appointer's capacity subsequently deteriorates.[48] This was intended to be an interim measure pending consideration of the broader issues by the Scottish Law Commission.[49]

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46 See Scottish Law Commission Discussion Paper 94, *Mentally Disabled Adults: Legal Arrangements for Managing their Welfare and Finances*, September 1991 paras 4.17 - 4.18

47 eg *Maule v Graham* 1757 Mor 3529 (friend managing affairs of incapax adult for more than 5 years); *Frenie v Robertson* (1871) 9M 437 (daughter managing affairs of senile mother for many years); *Dunbar v Wilson and Dunlop's Tr* (1887) 15 R 210 (brother managing affairs of mentally incapacitated adult for 2 years)

48 *Law Reform (Miscellaneous Provisions) (Scotland) Act 1990*, s71(1)

49 HL Deb 25 October 1990 vol 522 c1649

Unlike in England and Wales no procedure is necessary for validating a power of attorney following the appointer's loss of capacity, and there is no formal supervision of attorneys. However, the powers which can be exercised by the attorney in Scotland are limited to those specified in the deed - none will be implied, and there is no provision for general powers of attorney.

III The Bill

The problem which the *Mental Health (Amendment) (Scotland) Bill* is attempting to remedy is that which arises where a patient with limited funds which are being managed by a hospital (under section 94 of the *Mental Health (Scotland) Act 1984*) is discharged without being fully mentally capable. It has been estimated that around 150 patients in Greater Glasgow, and a corresponding number in other Health Board areas, are already in this position and that over the coming year a further 540 incapax patients could become so; and that the majority of these patients are likely to have only around £2,000.[50]

At present, although there is no provision in the *1984 Act* for termination of hospital management, it becomes unlawful when the patient is no longer liable to be detained or is no longer receiving treatment for mental disorder. However, if a person is discharged from hospital but is still legally incapable of managing his financial affairs or appointing an attorney, there is often no satisfactory alternative available. As mentioned above, the main method of dealing with the finances of incapable adults - curatory - is not usually viable where the funds are small; and the Mental Welfare Commission for Scotland has suggested that the majority of people in this situation do not have contact with relatives,[51] who might otherwise have been able to act informally on their behalf or be appointed tutor.

No similar difficulty exists in England and Wales, where the whole regime for dealing with the finances of incapable adults is substantially different. Hospital managers do not have any powers in this regard - instead the Court of Protection is responsible for arranging for the management of incapax patients' affairs, which can continue after the patient has left hospital.

The draft guidance on the managing the finances of incapable adults prepared by the Scottish Office in July 1998 discusses the implications of discharge of incapable patients to community care settings.[52] Health boards, their directly managed units and NHS Trusts, together with social work departments, are responsible for putting in place suitable alternative arrangements for the management of the financial affairs of such patients before the hospital managers relinquish their management responsibility.[53] The draft guidance stresses that these arrangements 'should form an integral part of the post discharge care plan or Care Programme Approach for each person' [para 1.33]. It goes on to discuss the relative merits of the various available mechanisms for looking after the

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50 Source: Scottish Office, 15 February 1999

51 Mental Welfare Commission for Scotland *Annual Report 1997-98*, 5 November 1998, p16

52 Scottish Office draft circular, *Protection of the finances and other property of people incapable of managing their own affairs*, 31 July 1998

53 section 12 of the *Social Work (Scotland) Act 1968* places a general duty on local authorities to give advice and assistance to people in need, and section 12A of that Act (as amended by the *NHS and Community Care Act 1990*) requires local authorities to assess the needs of people who may require such advice or assistance, taking account of other relevant professional opinions.

financial affairs of incapable adults [paras 2.5 - 2.32, and see Part II above], and sets out good practice for care home managers [paras 2.34 - 2.35.8] as well as examples of the kinds of goods and services that could be purchased through the use of personal funds of incapable adults [Appendix 2].

The Scottish Law Commission had suggested in its final report in 1995 that the scheme of hospital management of their patient's funds should be extended to local authorities running residential homes in relation to their patients, and could be extended to residents or patients in approved private hospitals and registered nursing or residential homes.[54] It also proposed that hospital managers should be entitled to manage funds only up to a prescribed limit for each patient, above which a Public Manager or a guardian supervised by the Public Manager should be appointed instead.[55]

The 1997 consultation paper on incapable adults [see Part IV below] rejected some of the SLC's proposals, and suggested instead that hospital mangers be authorised to continue managing the financial affairs of former patients following discharge where alternative arrangements are not in place. It described this as 'an interim measure to avoid gaps in the transfer of responsibility for managing individuals' finances from hospital managers to alternative arrangements', and sought views on whether a specific time limit should be placed on the hospital's authority from the date of the patient's discharge.[56]

The main clause of the present Bill [clause 1] is intended simply to extend hospitals' powers to hold and expend money and valuables under section 94 of the *1984 Act* to patients who are no longer detained or being treated in hospital. It is envisaged as a temporary measure pending comprehensive litigation in this area by the Scottish Parliament.[57]

This provision would apply only to those whose finances were being managed by the hospital prior to their leaving it, and would not allow hospitals to become managers of the funds of those who are being cared for in the community but who have never been in hospital. Nor would it allow the hospital to receive any further funds on the patient's behalf. There is no limit specified on the time during which a hospital could continue to exercise these powers, nor are any provisions for termination of the powers given.

The decision to present the Bill was welcomed by the Scottish Office. The Scottish Health Minister, Sam Galbraith, commented:

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54 Scottish Law Commission No. 151, *Report on Incapable Adults*, September 1995, paras 4.42 to 4.45

55 Scottish Law Commission Discussion Paper 94, *Mentally Disabled Adults: Legal Arrangements for Managing their Welfare and Finances*, September 1991 para 4.167

56 Scottish Office, *Managing the Finances and Welfare of Incapable Adults*, February 1997

57 Eric Clarke's synopsis of the Bill, *The House Magazine*, 25 January 1999, p12

> This is a small Bill but it will make a big difference in the lives of many patients who leave hospital. It means they can continue to benefit from their personal resources when they are being cared for in the community.
>
> This is a much needed reform and Mr Clarke is to be congratulated on introducing the Bill which will help resolve a difficult situation until comprehensive legislation dealing with the management of the finances of incapable adults can be enacted in the Scottish Parliament. On behalf of the Government, I warmly welcome this Bill and I will be doing all I can to assist its passage through Parliament.[58]

At the time of writing the Bill had not yet been printed, so formal responses from relevant organisations based on the actual text were not available. However, a number of organisations have made general comments on the principles of the Bill.

The Scottish Association for Mental Health (SAMH) welcomes its introduction 'in so far as this small Bill represents an improvement to an unacceptable situation'.[59] However, the Association also raises the issue of the need for safeguards to ensure that funds are managed in the best interests of patients. In particular it suggests that there should be a time limit such as 6 months after which the hospital would have to justify continued management, provisions to allow for the reassessment of the patient's capacity to manage their own funds, and a right of appeal against the certification of incapacity. The Association also highlights the lack of authorisation for the hospital either to receive new funds, or to gather interest on behalf of the patient. More generally, SAMH emphasises that this should only be seen as a 'stop-gap' Bill, pending the introduction of more comprehensive legislation covering the whole area of the management of affairs and decision-making of mentally incapacitated adults.

The Law Society of Scotland is in favour of the provisions of the Bill, stating that 'it will solve a problem which is affecting a substantial number of former hospital residents in Scotland', and has urged MPs to support it.[60] The Mental Welfare Commission for Scotland, commenting on early proposals for such an amendment, said that it 'would be of some temporary help, but not to those already in the community when they become incapable of managing their affairs'.[61]

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58 Scottish Office news release 48/99, 13 January 1999

59 SAMH, letter to Scottish Members, 3 March 1999

60 Letter to MPs from Michal Clancy, Director for Legal Policy and Communications, Law Society of Scotland, 8 March 1999

61 Mental Welfare Commission for Scotland *Annual Report 1997-98,* 5 November 1998, p 6

IV Wider reforms

Following its 1991 Discussion Paper on the subject,[62] the Scottish Law Commission produced its *Report on Incapable Adults* in September 1995.[63] This identified the inadequacies of and gaps in the current law, recommended an almost entirely new system, and proposed draft legislation to implement it. Those of its proposals relating to the financial affairs of incapable adults could be summarised as follows:

- general principles to underlie the whole of the draft legislation, including the principles that (i) any intervention must be for the benefit of the incapable adult concerned and be the least restrictive to achieve that benefit; (ii) the past and present wishes and feelings of the adult and of others close to him should be taken into account; and (iii) incapable adults should be encouraged to exercise their existing skills and to acquire and develop new skills;
- people and their carers should be enabled and encouraged as much as possible to make arrangements for possible future incapacity;
- a scheme whereby a carer looking after an incapable adult at home could be authorised to withdraw money from the adult's bank or building society account to meet the adult's living expenses;
- the managers of hospitals and other approved establishments would be authorised to manage income and certain other financial matters on behalf of their incapable residents;
- a new public official - the Public Guardian - would have a regulatory, investigatory and supervisory power in relation to institutions managing finances, continuing and welfare attorneys, and individuals authorised to access people's bank accounts;
- the Public Guardian would be able to undertake management of small estates where professional management would impose too great a burden; and
- in the absence of satisfactory formal or informal arrangements the court would have the power to make intervention orders (for one-off situations) or guardianship orders (for continuous management or assistance over a lengthy period). This is intended to form a flexible but coherent system, in which the powers conferred would be limited to the incapable adult's particular needs and abilities, and could deal with personal welfare or financial issues or both.

The previous government broadly accepted these proposals, and issued a public consultation paper in February 1997 on *Managing the Finances and Welfare of Incapable Adults*,[64] which also considered the resource implications of implementing the Scottish Law Commission's report. Alternative arrangements were proposed in a few areas - for instance the government believed that the Public Guardian would not be the appropriate

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62 Scottish Law Commission Discussion Paper 94, *Mentally Disabled Adults: Legal Arrangements for Managing their Welfare and Finances*, September 1991

63 Scot Law Com No. 151, Cm 2962

64 Scottish Office, February 1997

body for registering institutions for the purposes of managing the financial affairs of their incapable residents; and it did not consider that it would be cost-effective for the Public Guardian to undertake the management of modest estates.

The need to reform the law in this area has also been accepted, in general terms, by the present government. Particular aspects of the Scottish Law Commission's 1995 Report with which the government has expressed its agreement are:

- the general principles proposed by the SLC that any intervention should produce a benefit for the adult; be least restrictive of the adult's freedom; wherever possible encourage the adult to use existing skills and acquire new skills; and take account of the present and past wishes of the adult;
- the proposed definition of mental incapacity;
- the current office of the Accountant in Court should be expanded to form a new office of Public Guardian;
- the function of the Public Guardian should be to maintain public registers of all those authorised to take decisions on behalf of an incapable adult and to supervise and monitor the performance of financial guardians;
- the recognition of continuing and welfare powers of attorney and the introduction of public scrutiny of the exercise of such powers;
- the creation of a new concept of guardianship for a broad and flexible system of one-off intervention orders and longer term guardianship, with appropriate welfare or financial powers as ordered by the court; and
- the key decisions on applications, and in other proceedings under the proposed legislation, should be dealt with in the sheriff courts.[65]

However, the government would vary the Commission's recommendations as follows:

> We propose to modify the SLC scheme for carers in domestic settings to have access to funds from the bank accounts of incapable adults, in order to meet daily living expenses. Under the revised scheme, the Public Guardian would grant authority to have stipulated payments made for a time limited period from the incapable adult's account to a designated account. The Public Guardian would have powers to check that the incapable adult's funds were being applied for the intended purpose.
>
> We propose to modify the SLC recommendations that residential homes should apply to the Public Guardian for authority to manage residents' finances. Under the revised proposals, registration and inspection authorities in local authorities and Health Boards would authorise the managers of residential establishments to manage the funds of residents who are incapable of so doing, up to prescribed

[65] Henry McLeish, opening address to conference organised by the Alliance for the Promotion of the Incapable Adults Bill, reported in Scottish Office news release 2657/98, 16 December 1998

> limits, and in circumstances where no other arrangements would be appropriate for managing the finances of these residents.
>
> We do not propose to follow the SLC recommendation that the Public Guardian should be able to be appointed as financial guardian to an incapable adult. We take the view, however, that the arrangements recommended for withdrawals from bank accounts and for intervention orders, and also for management of finances by residential establishments, should be sufficient to meet the needs of incapable adults with modest estates.
>
> The Public Guardian's functions will be focussed on maintaining public registers of guardians and monitoring and supervising guardians with financial powers. Local authorities and the Mental Welfare Commission will monitor those exercising welfare powers on behalf of incapable adults.[66]

The issue of 'advance directives', which would allow people to set out their own medical preferences or nominate people to decide on their medical treatment, had been looked at by the Scottish Law Commission and included in its draft Bill; but the government has yet to make a decision on this matter.[67]

The government's view is that any legislation in this area should be a matter for the Scottish Parliament and that any statements cannot therefore pre-empt announcements about the Scottish Parliament's legislative programme.[68]

In addition to this initiative, a committee has been set up to carry out a major review of the whole of the *Mental Health (Scotland) Act 1984*. It will be chaired by the Right Hon. Bruce Millan, and its report is expected in the summer of the year 2000.[69] The terms of reference of the committee are:

> In light of developments in the treatment and care of persons with mental disorder, to review the Mental Health (Scotland) Act 1984, taking account of issues relating to the rights of patients, their families and carers, and the public interest; and having particular regard to:
> - the definition of mental disorder;
> - the criteria and procedures for detention in and discharge from hospital;
> - leave of absence and care outwith hospital;
> - the role of the Mental Welfare Commission for Scotland;
> - the findings of the Committee set up to review the arrangements for the sentencing and treatment of serious violent and sexual offenders, including those with personality disorders;
>
> and to make recommendations.[70]

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66 *ibid*
67 HC Deb 16 December 1998 c154
68 *ibid*
69 HC Deb 8 December 1998 cc133-4
70 Scottish Office news release 0392/99, 22 February 1999

In September 1998, the Secretary of State for Health, Frank Dobson, announced a review of the corresponding legislation in England and Wales - the *Mental Health Act 1983*. Professor Genevra Richardson is chairing a study group set up to identify the main issues to be addressed in the review of that legislation. The procedures and mechanisms for making decisions on behalf of incapable adults in England and Wales have also been the subject of separate consultation: the Lord Chancellor's Department published a green paper *Who Decides?* in December 1997, following the Law Commission's 1995 report entitled *Mental Incapacity*.[71]

[71] Law Com No 231, HC 189 1994-95, 28 February 1995