

Scottish Mental Health and Incapacity Law Review  
Compulsion group meeting 23 June 2021

Present: Graham Morgan, Jill Stavert, John Scott, Neil Robertson, Elinor Dowson, Roger Smyth, Gordon McInnes, Laura Dunlop, Laurence Nicolson, Michael Craggs

Review secretariat: Simon Webster

John gave an update to the group following the Executive Team's (ET) recent development days. The ET has looked at the final deadline for the work, September 2022, has worked backwards from that date with the secretariat, and has considered risks. The ET needs to do a lot of work in a relatively short period of time over the summer, and to pull together the discussions from advisory groups and reference groups along with consultation responses. Given the timescale, and to allow the advisory groups to continue to be more focussed, the ET has decided to do more work with what has come out of the groups so far. Some groups are getting very close to the end of their work and others including Compulsion are not. Some groups will wind up very soon, and others including Compulsion will pause until after some intensive work by the ET. The Executive will come back to continuing groups with thoughts and further discussions, leading to targeted discussions. A letter will go to all involved in the review, explaining that the ET needs to work in this way. The ET will spend two months over the summer, pausing advisory groups, and regrouping around September with some advisory groups finishing completely now. John emphasised that the ET is very appreciative of the group's work so far. Graham and Jill agreed with this.

The minute of the previous meeting was agreed with changes:

'the issue of when advance statements apply and when they can (if ever) be adhered to seems to involve compulsion at least potentially.'; and 'Brenda Hale'

Alternative approaches had been discussed such as Open Dialogue and 'Drop the Disorder', and it was highlighted that the 2003 Act does not include the idea of recovery. Concern was raised that going with the principles as before with a few extras would not be enough and did not want to lose sight of these things. It was confirmed that this is still in the action plan to discuss these things after the summer when the group comes back, along with other approaches to early intervention.

Speaking to the paper on the purposes of the act the following points were raised:

The current idea of supported decision-making may conflate two different scenarios: one where the person can't tell you what their wishes and feelings are, for example, due to serious dementia; and another scenario where the person is telling you what they want, and the support is to implement the decisions that the person makes. These scenarios raise different issues – for example, the person in the second scenario may not want to be in hospital, on medication, or have family involved. If we are retaining compulsion then there will be situations in which those wishes will be overridden.

There was a discussion around the gold standard of support for decision implementing and the differences between advocacy and non-instructed advocacy. Advocates will come to Tribunal hearings and say what the person wants without passing judgement, which is an essential ingredient and is indispensable.

It was suggested that both may be needed.

Need to be careful that non instructed advocacy is not 'rebranded' as another form of coercion.

On reciprocity, Reciprocity should not be made a criterion for denying the best support, but could highlight where there is a denial of rights.

Since the removal of the default named person, there has been problems with getting invited for some family members, especially for – for example – older people with dementia. There can be a lot of tension about family involvement and many find it difficult to give a view: the person may agree that measures are necessary, but this can lead to issues with the relationship.

It was thought that taking reciprocity out would be a bit of a cop-out. It is the hardest of the principles to implement, which is down to having no resources to implement it properly. It is necessary, but we need to look at the whole provision of care – compulsory treatment is not like going to see your doctor on a voluntary basis.

It was also highlighted that social circumstances reports are not shared with the person whom they are about.

It was commented that reciprocity could be about looking to see that everyone, voluntary or detained, has a right to health services: reciprocity which applies to everyone, not as a guarantee to get services. It was pointed out that this is different if a person is being forced to use those services, which should require a bit more effort from those providing care and treatment.

From that work of the Capacity and Supported Decision Making workstream it was clear that there is a need to keep the person's voice alive at all times, transcending any assessment. Support will need to be multifaceted to help people with decision-making. We need to make sure that support is in place when a person cannot communicate, making a best interpretation if all else fails, ensuring that this is genuinely what the person wants. This does not mean that the person's wishes at all times will override everything else. There will be a need to work on a shared understanding of what we are talking about here.

One-to-one advocacy and non-instructed advocacy could be part of supported decision making – with not just one type of support for decision making, as different things will work at different times and in different circumstances.

It was agreed by some that there is a need for compulsion. A distinction was drawn between non-consensual treatment (for example, for some people with dementia) and involuntary treatment with people who can express a view, who can object and do object, there are different practical and ethical challenges here, which raise different questions; mainly, should the law allow for involuntary treatment? It is easy to slip into euphemisms about 'protective custody' and we need to be clear that what we are proposing will sometimes be in direct opposition to what a person wants. Non-consensual treatment can be about how to get previous views and knowledge from relevant others, and how to find out more through effective communication. With involuntary treatment, we can know the person's voice but would have to decide about ethics, criteria and practicalities.

Need to take account of the person who comes into hospital who cannot make a decision who needs urgent medical treatment. There would at least need to be legislation for those cases for physical health emergencies, to support practitioners to remain lawful in doing things that are covered by common law powers. If it was decided that there should be

involuntary treatment in certain circumstances, there would have to be decisions made on criteria, applicability, and appeal processes.

It was agreed that views on Compulsion would be sought from the Royal College of Psychiatrists.

People often act as advocates with conflicts of interest, such as staff, and that advocacy has no real powers. There may be a need for an independent arbiter that people can work with. In Glasgow, independent advocacy is funded by the NHS when you are under the Act. The service can't do any proactive work or work post-discharge. This ties back to the point about reciprocity: we need to get views on care and treatment for people with previous admissions and to record that as a matter of fact for all people who have been under the Act (which may still not cover first admissions or dementia). People feel that a lot of issues are rubber-stamped, and that no-one challenges the doctor.

It was questioned whether this idea would be similar to advance statements.

Reciprocity is not just about services, but about support to move on with life. Services are not good enough, as these are different in each area, and they can be very poor in some areas. It was thought that advocacy had not been implemented properly at all. There are not enough advocates, and carers did not get a right to advocacy.

Concern was raised that there can be a solicitor, advocate, family member and the person all speaking up, but still no one is listening despite all speaking very clearly.

The group discussed how Australia was addressing these issues. There is a lot of variation between federal states in Australia, but all have kept a level of compulsion in mental health law. The most recently-reviewed law is much more supportive of patients' autonomy and introduces support for decision-making. However, that law still has a way to go.

The group discussed section 12 of the Social Work (Scotland) Act, as it was comprehensive and could be stretched to provide all sorts of things. section 12 underpins much of what social workers do, but in practice, it is not only used to give financial assistance – for example, to people who turn up at the social work office and are suffering from destitution.

There was a discussion on being detained on the basis of mental illness. Issues were raised about CTOs and the criteria which require medical treatment to be available, and about significant risk if this treatment is not provided. It was felt that these criteria remove those people's rights. It was suggested that there should be compulsory support, not a requirement for adherence to treatment – most people don't like medication, but you could have CTOs which provide support and which people don't mind being on.

It was suggested that there is no settled diagnosis for many conditions and it was suggested that it is fundamentally unsound to give RMOs a veto over not just views of patients, but also other doctors and social workers. Somebody asked what had happened to calls to increase the roles of psychiatric social workers, including community based treatments.

1. Do you agree with the approach taken by the Executive team on non-consensual treatment?: Yes

2. If we agree there should remain some form of non-consensual treatment , what is needed to make it different to the way things are at present? For example it is suggested that non-consensual treatment needs to be protective and enabling? What needs to be put in place to make sure that happens?:

This is very difficult to answer. We would all agree that we want 'protective and enabling', and no-one working in the field is motivated to carry out 'punitive or limiting' actions.

3. The paper says more weight should be given to people's will and preferences- and non-consensual interventions should be rarely coercive – do you have suggestions for how this could be achieved?: Graham noted that there had been no objection to the paper so far.

Roger's view was that the paper does answer some fundamentals. On the question of whether there should be non-consensual treatment in Scotland, the paper explicitly states an executive view. It was felt that the idea that diagnosis is super-important is not true, and that the updates to the diagnostic manuals will not change the categories of severe and enduring mental illness which lead to compulsion. An example about a case involving anorexia was provided as a 'hard example' and the issue of anorexia and non-consensual treatment was discussed further.

It was felt by others that there should be some element of compulsion in extreme circumstances but that that should trigger a lot more entitlement and attention to the patient's care especially relating to decision making. This will have resource implications.'

Issues were raised as per the Strang report which identified people who had a different diagnosis at least three times, it was felt that this will be happening all over the country, and that pharmacists are well aware of this. Concern was raised about the ease with which non-consensual treatment can happen, and the link between non-consensual treatment and poor community services.

Everyone agreed that in some circumstances, non-consensual treatment should happen. Although there had been very strong criticism of the system, all seemed to agree on that.

Secretariat

24 June 2021