Scottish Mental Health Law

Meeting of the Compulsion Advisory group
20th April 2021

Present
Graham Morgan, John Scott, Simon Webster, Laura Dunlop. Michael Craggs
Gordon McInnes Jennifer Whyte Roger Smyth Elinor Dowson

Apologies –Laurence Nicholson

Kirsty McGrath , Nicola Paterson , secretariat

Due to an administrative error, Neil Robertson did not receive the notification for the meeting. We have apologised to Neil and put steps in place to make sure this does not happen again.

Discussion

Graham welcomed everyone, Kirsty gave a brief update on the Review, mentioning the 2 reference groups that have had their first meeting. The action plan for the group was agreed, with the group agreeing to meet in June, August and September.

Simon Webster, research consultant to the Review introduced himself and explained some of the work he will be doing across the Review.

Graham then explained that today's discussion will be around the effectiveness of compulsory measures of care and treatment and people would have a chance to give views they may not have been able to express in earlier meetings.

~~Michael had~~ 3 points were raised on the theme of diagnosis. Many people who have repeat admissions don't accept their diagnosis –is the law helping this situation by forcing a diagnosis? People with borderline personality disorders are often dealt with by A and E in a crisis situation –but not given any thing to support them, when the crisis has passed and people with co morbidity/ substance misuse are often treated for one diagnosis, with the other left.

in terms of attitude a person's views on their diagnosis should be recorded. It may not change diagnosis but it is important to have that alternative view. And instead of capacity we should look at risk – it might be more uncomfortable but we often attribute things to capacity when it really should be risk

The current act is well grounded in human rights and there needs to be a particular reasons to deprive someone of their liberty. There must be specificity of diagnosis so people understand why they are being detained.

Emergency services that can't say no will often help people who are waiting on services who add them to a waiting list. Must be mindful that if you provide treatment for a person who is detained there could be a perverse incentive for treatment.

it is often not the underlying diagnosis, but the current risk that can drive things to a head. What we need to consider is whether we are detaining people appropriately and not detaining those people who given care at the right time would not require compulsion.

It Is helpful to remember why diagnosis is so important – it is to take us away from the fear that a person may be detained simply because of dissent from government orthodoxy.

But need to ensure diagnosis is a key and not a millstone. As a society we are risk averse and that impacts on decisions made.

It was felt that anything that deprives someone of their liberty or involves compulsory measures of care need careful consideration. The woollier the diagnosis, the more wriggle room there is. If you articulate on the basis of a narrative account of a person's thinking, you can go round the houses. The old Act required a long description of symptoms without the ability to pin doctors down on exactly what they meant in the diagnosis. A lack of specificity means more power for doctors.

It was suggested that the Glasgow coma scale could be considered for risk or degree of decision making. There has been a lot of interest in this approach but none have proved any more effective than a clinical diagnosis.

It was felt that if a person's reality is blankly denied it can be hard to think of non-coercive ways of dealing with this.

If you compare the law to detain a person based on infectious disease against that of mental health detention, one can predict the risk from Ebola but you can't predict the risks from severe psychosis in the same way. Criteria is needed but could it be measured by risk of harming others, suicide risk?

It was suggested that the ideal is operational diagnosis (diagnosis only in line with internationally agreed standards). There certainly are individual practitioner whose diagnosis of condition is not in line with standards. However, in the absence of standard diagnostic criteria used by the majority of practitioners this aberrant practice would be even harder to identify.

It was highlighted that there was strong evidence in the Strang report that people were getting 2 or 3 different diagnosis, and medication for 3 different things, then ending up in hospital as the medication was making them unwell. This issue is exacerbated by so many locums. Different diagnosis by different people is a fact. It was also felt that reciprocity is mainly forgotten about It is much than just keeping people safe, it should be about improving peoples' lives.

A therapeutic relationship can be the key to keeping people out of compulsory measures of care.

John said that the theme of good relationships had been clear from the start of the review. Psychiatry is still developing but it needs checks, controls and accountability in place. Human rights are one way of allowing folks to know what they are entitled to.

Following the Strang report in Tayside they are looking at changing the whole culture, more use of community services, using pharmacists to check people's medication rather than psychiatrists- if this is successful this could make a big difference to people's lives and their ability to function with the right level of medication.

Members of the MHTS are very aware of reciprocity and this is addressed by using recorded matters.

The key idea behind reciprocity is that if the state places obligations on you (e.g. to stay in hospital, take medication) then it has an obligation to provide services. Perhaps these services could be specified in care plans with a statutory duty on Boards and LA to provide?

But what sanction could there be on Boards and LAs if not provided? Detention automatically revoked? But would this subject patients to unacceptable risk? Fines? But this further diminishes resource?

It was commented that there ~~sin~~ is nothing worse than defining people as a noun – eg. A schizophrenic. Much better to say someone is experiencing schizophrenia.

All agreed reciprocity is an issue. How do we minimise the risk of achieving care only by detention?

It was felt that there is a need to record people's opinion of psychiatric care. It should be part of the decision making process so people feel they are being listened to. There is a need to build trust as a 2 way thing. Relationships matter to quality of treatment and safety of the person.

In Tayside they are looking at there being one door for getting help, bringing in the 3rd sector, providing peer support, this could make a huge difference to people.

There was a word of caution about paradoxical outcomes. Advance statements have not been as useful as hoped but the requirement under s 24 to enable mothers to care for their child in hospital for a year after giving birth, if they require hospital care has made a huge difference, .

We really can do a lot with the law to increase provision but we do not want to mirror the English situation where you need to get detained before you a get a bed. It's important to keep at the back of our minds whether anything we do will increase or decrease detention.

Whatever we do must be a tide that lifts all boats, not just the most articulate/ best resourced individuals.

Perhaps we need to look at how people exit the system –People are in the system for too long – innovation here could make things tighter.

We need to be wary as new services take a long time and are not always welcome.

It was agreed that it can be difficult for people to leave services. It was suggested that there should be more structural peer support work within the NHS and more detailed plans for community care so groups can have more confidence to manage people

Secretariat 20/4 /2021