Minutes from the Executive Team Meeting

Date: 9th November 2021

Video Conference Meeting

Present: John Scott, Colin McKay, Jill Stavert, Karen Martin, Graham Morgan, Alison Rankin
Secretariat: Sophie Ryder, Sandra Macdonald, Isla Jack, Simon Webster, Karen Colvin
Apologies: Kirsty McGrath

Feedback on meetings

Sikh Sanjog based in Leith – planning to hold focus group, TBC. This will include separate meeting for their youth group and a face to face meeting with their older members who don't have the same access to technology in the new year.

Meeting with LGBTI on 11th November, speak to them in general about review and the possibility of a focus group.

Feniks –organisation that supports the central eastern European community. Meeting scheduled with the chief executive officer on 24th November to endeavour to find out the best way of engaging with this community.

Email to be sent to ET and secretariat each Thursday listing the following weeks consultation meetings, if anyone not already invited wishes to join contact secretariat support to send link and papers.

MHTS

Meeting with Mental Health Tribunal Scotland. Getting them to engage with vision as to where they see the tribunal going. Could it adapt to fusion legislation for example?

MHTS have a newsletter which is read by tribunal members. This could be a way of reaching out to members of the tribunal to seek their views on this.

Discussion of paper – compulsion – preliminary views of the Executive Team

Graham introduced the paper and provided a summary. The paper received a mixed reception from the advisory group on involuntary care and treatment. It was acknowledged however that had the ideas been framed in a different way, this may have elicited a different response. This is something to think about in the future when presenting ideas for feedback. This could be introduced by 'We need to do a lot to change culture and practice in order to reduce coercion'. It is also important to acknowledge, however, that coercion is a harm, albeit to prevent a bigger harm.

Is there anything that has been missed?

- Specifics are missing at the moment such as time limits on STD.
- The MWC recognised that there is a lot of unlawful practice going on in relation to STD's, it was acknowledged however that it people are breaking the law, we need to get better at stopping this, it is not an issue around changing the law.
- We also need to say more on advance planning
- De-medicalising crisis support, came across strongly in the event with the Royal College of Psychiatrists and something we need to be aware of.
- There is also more general work to be done around CTO's and STD.

Colin then spoke to the paper and the following points were raised;

- The way that the paper was put together can inform the presentation on things in the future – agreed
- Compassion needs to be included within the things that need to change
- In the wording 'don't think mental health law, as it currently exists, needs to change' – can we remove 'as it currently exists'
- It should be linked into the assessment framework more
- The term 'coercion' needs to be defined amongst ET members. The term has been used to capture 'every form of intervention without consent' but others have used the term in a more restricted way to describe acts that are resisted.
- There is a blurriness between legal provisions and subjective experience in this regard.
- Would there be a benefit from mapping out interventions as coercive and non-coercive?

- There is also the issue of informal coercion and where this sits. For example, if somebody is told that if they try to leave, they will be detained. In this situation there is no ability to challenge.
- Need to also be mindful of structural issues that act as barriers, which include the actions of the local government and the NHS. Until there is greater investment we will not see a reduction in coercion. As lack of support in the community means that there is nowhere to go.
- Concern raised over prescription of antipsychotic drugs for people living with dementia. There is a lack of knowledge and understanding to argue with this, which reinforces the power of the medical practitioner.
- Health literacy – Compulsion / Coercion - people don't know what it means, lack of understanding. Needs to be very clear. Imbalances power.

There will be a follow up paper on community services.

- Dementia patients are knowingly being prescribed harmful drugs. Evidence suggests that these drugs make a small difference, but there is stronger evidence to show that these drugs can cause death.
- We need to be mindful of how anti-psychotics are prescribed in the context of a human rights assessment and whether there is a requirement to show that the benefits of administering this vs the side effects have been considered from a holistic perspective.
- We also need to consider how the law is framed around administering medication coercively.
- For elderly people there are no safeguards in practice and this needs to be challenged.

Policy and Practice

- There needs to be co-ordinated training a professional development.
- There also needs to be user's involvement in the design and development of training.
- Lots of problems relating to mental health are related to respect and dignity. It's often in the small things were people aren't given the respect that they deserve and are not made to feel like equals.

The group agreed the paper in broad terms but acknowledged that further work needs to be done. This includes;

- Agree definition of coercion
- Health literacy
- Prescription of anti-psychotics
- Coercively treating people with dementia

The next step is also to look at where coercive practices would go.

- It is important to consider how services are attuned to different communities, thinking about those who are marginalised and often alienated from services, this could be for things such as religious beliefs. These people may be more likely to be subject to compulsion.
- There is also a need for preventative services and early intervention such as crisis houses, community wellbeing hubs, peer support and open dialogue, planning for crisis and shared decision making. Places of privacy and community connections to wards.
- At a hospital level we should consider things like the physical environment and how this could be made more inviting, relaxed and comfortable.
- In tandem with this we need to look at demands of jobs within the mental health sector and lack of resources

Other points raised;

- Emphasis needs to be placed on the value of reducing coercion and how this is measured.
- Further work on CTO's and STD certificates.
- Piers Gooding described CTO's as ineffective due to the fact that they didn't reduce hospital admissions. Need to question why this outcome meant that they are classed as ineffective, is this based more on perceptions?
- Value in Lived Experience research and possible links to collective advocacy movement.
- Also need to look at the term 'mental disorder'. This is something that is contentious to a lot of people and we need to come to a decision on the term that we will use.
- Consideration of the Rome Review is also important and will be added to the project plan.

Headings from CMc paper on “Compulsion – preliminary views of the Executive Team”, Autumn 2021

Stronger safeguards when compulsion is authorised	Human rights assessment
	Greater support for decision making
	Strengthen advocacy and the role of the mental health officer in identifying alternatives to compulsion
Stronger safeguards for individual coercive interventions to prevent trauma in detention	Strengthen Part 16 of the 2003 Act
	Further safeguards for restraint, seclusion and other non-medical interventions
	Further safeguards for coercion authorised by welfare guardians or attorneys, or under Part 5 of the AWI Act
Monitoring and scrutiny - systematically monitor particular coercive interventions and interrogate why they are being used	Systematically monitor particular coercive interventions and interrogate why they are being used
	Systematically monitor particular coercive interventions and interrogate why they are being used
	Systematically monitor particular coercive interventions and interrogate why they are being used
Policy and practice	Systematic improvement programme led by Scottish Government and involving services, people with lived experience and regulatory bodies, over several years, to reduce restrictive and coercive practice across the mental health system
	Co-ordinated training and professional development across mental health services, to develop a consistent understanding of a human rights-based approach to mental health care
Respect for economic, social and cultural rights - mental health law should fully reflect economic, social and cultural rights, including the right to health and the right to independent living	Strengthen the duties on public bodies to provide appropriate services, particularly in the community, to reduce the need for compulsion, and particularly to reduce the duration of compulsion where it is necessary
	Provide remedies and access to justice where people do not receive the support they can legitimately expect as an alternative to compulsion
	A commitment by Scottish Government and other public bodies to test out new service models and to ensure innovations which reduce the need for coercive practices are spread across the system
	As part of the development of Scotland’s human rights journey, policies need to develop which address the social determinants of mental ill-health, including poverty, discrimination and inequality

Actions:

JS – The 7th Dec is the deadline for submitting abstracts to World Congress on adult capacity – do we want to put something forward? Who wants to go to speak? What we want to ask for, parallel session? Deadline looming.
To be discussed at next ET meeting and added to project plan.

IJ – In December meeting we should be looking at the issues cutting across various workstreams.

JS – Forensic paper to be revised.

Secretariat – SMHLR
09/11/21