REDUCING COERCION

GRAHAM MORGAN MBE

This is a transcript of a talk by Graham Morgan MBE – Mental Welfare Commission for Scotland – to the Third UK and Ireland Mental Health and Diversity Law Conference, July 2023. Nottingham (England.)

Graham drew on the Report of the Scottish Review into Mental Health Legislation[1] *for this talk and for a better understanding of how he thinks coercion could be further reduced would especially recommend reading the chapters on Human Rights Enablement, Autonomous Decision Making Tests, Supported Decision Making and Economic Cultural and Social Rights.*

I am speaking as the Past Joint Vice Chair of the Scottish Review into Mental Health Legislation and the lead for its coercive treatment workstream. I am also currently on a compulsory community-based treatment order ('CCTO') and have a diagnosis of schizophrenia.

I work for the Mental Welfare Commission where I regularly meet with people with lived experience of mental illness and of detention.

First of all an apology – I am familiar with Scottish Legislation but less so with that of other countries. Just to set the context; my CCTO means that I am legally obliged to accept my fortnightly injection and to see psychiatric staff and let them into my house for my care and treatment. I go to a tribunal every two years when it is renewed and so far, see no prospect of that stopping.

First: the Scott review and coercive treatment. We cannot avoid the fact that treatment carried out against someone's will, sometimes involving force, is by its nature coercive. This does not have to mean that the people doing this are carrying it out with malicious intent and with the wish to cause harm; in reality we believe that the intent behind most forms of coercive treatment are to avoid much greater harm and that this is usually what happens in practice.

However even though such actions are often carried out to save life I can still vividly remember running down corridors with nurses chasing me and alarms blaring and hate the memory of having a nurse follow me wherever I might go even when I went to the toilet or the shower. I know it was done to stop me harming myself but when I visit a hospital nowadays and hear the alarm go off or see people on 'constant obs' it can bring me back to difficult times in the past. It is for these sorts of reasons that we agree with the Royal College of Psychiatrists that coercive treatment is often traumatic and people need help with this trauma.

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[1] Available via: https://webarchive.nrscotland.gov.uk/20230327160310/https://www.mentalhealthlawreview.scot/ (accessed 19 July 2023).

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We agreed that forms of coercion will need to continue for the foreseeable future and that maybe it will never be possible to eliminate it. We based these opinions on the evidence provided by people with lived experience in Scotland and on international evidence that we obtained but in keeping with Piers Gooding's research[2] we think we should work towards the eventual elimination of coercive treatment, if at all possible.

Regarding reducing coercion, I am going to fall into my idealistic 'what if' mode. I think mental illness, however we define it and however we see trauma and the social environment as a part of it, is a horrific experience. I have a terrible feeling that some people think that if people were just nice to us and kind and addressed a few inequalities that face us everything would be ok, but we can enter realms where our reality is not amenable to reason and we can find we have emotions and behaviours that, far from being the grateful awkward response to the offer of support are raw wild expressions of grief and pain and anger. We do not always seek out help; sometimes all we feel is pain and pain is rarely something that we can easily deal with. It can be utterly disruptive and destructive even when we are begging and not begging for help at the same time.

This is, I think, one of the key reasons why coercive treatment is sometimes needed and will continue to be but to contradict what I just said; I do believe that if we have a society and services where belonging and trust are taken for granted, then kindness and the very love and compassion this implies may prevent alienation and otherness. If we had a society and services where people like me are not looked on with suspicion and fear, then maybe we would not look on society and services in turn, with the same fear. Maybe distress would not get to the point that coercion is necessary or the preferred route.

If we had services we could turn to in the community, such as community and peer support as well as Wellbeing hubs and some alternatives to hospital when we are in crisis. If Psychiatric emergency plans were living documents and the infrastructure of community services were truly in place. If hospital wards were designed so we want to be there and are made to feel safe rather than a clinical environment we feel alienated in and if, in future, new buildings are informed by our lived experience and look at reasonable adjustment and universal design we might end up with something we appreciate but which also serves its purpose well.

If we had policies like 'Safe Wards' adopted in hospital and if we can align between the human-rights based approach which we recommended, and the recovery approach: into an approach which would include mutual support, hope, appreciation, being valued, having people 'on our side' and having activity which we value and in addition, if we had the beds we needed when we needed them and if our friends and relatives were listened to and supported. And If we anticipate crisis and relapse with genuinely participative joint crisis planning which comes into effect before we lose capacity, then maybe we would cope better for longer, have better lives and when, as

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[2] Gooding, P., McSherry, B., Roper, C., & Grey, F. (2018). Alternatives to coercion in mental health settings: A literature review. *Melbourne: Melbourne Social Equity Institute, University of Melbourne*.

will always happen, life falls apart, maybe we will have safe places and people to go to without coercion becoming necessary and. if it does, maybe it will be less often and for less time. That is the hope.

As I said hugely idealistic and, quite rightly, we had many replies to our consultation saying for these things to happen we need resources; that this is less a question of legislation and more about services. And yes it is. It is all about resources, as is developing community and trust and knowing we are a part of our communities. It is more than investing in mental health services; it is about investing in our society, investing and valuing staff and in the elements that mean that some of the most isolated people of all feel a part of and welcomed.

We found out many international approaches which have been shown to reduce coercion but rather than dictate what we want to happen years and years before anything is implemented in Scotland we suggest that we have an improvement group with lived and carer experience central to it which looks at and makes recommendations, alongside government, about some of the approaches that may ultimately lead to less coercion in the future but which also in line with our economic social and cultural rights, help create a better quality of life for us. Alongside that we need to invest in research into these issues, especially coercion, and to encourage high quality lived experience led research.

Regarding detention, I mentioned trust and belonging at the beginning and also different communities of people. We think we should learn from research carried out by the Mental Welfare Commission and elsewhere to make sure that the treatment of people from diverse ethnic communities is such that all assessments have been made on the same basis as for all people. People should have been offered at least the same level of support for decision-making as for any other person. Their cultural, linguistic, religious or belief requirements should have been identified and professionals need to show how these needs will be met. If they or their supporters have said that racism or cultural insensitivity may be present we need to know these issues are being addressed. We also want to be sure there is culturally appropriate collective advocacy that the Government will resource and will also empower leaders of Scotland’s minoritised ethnic communities to lead on solutions which ensure access to mental disability services for their communities. It should also address racial discrimination through an approach which develops the Patient Carer Racial Equality framework, with monitoring and enforcement by scrutiny bodies.

My personal opinion is that comparable actions should also happen with other marginalised communities who, I imagine, future research might also reveal comparable levels of discrimination in mental health services and coercive treatment.

Despite the considerable amount of research that has been done into rising rates of detention here and elsewhere it is very hard to tell why a rise or reduction in detention rates has happened. It may be that a rise in detention reflects a rise in rates of mental illness and that with austerity and economic hardship; crisis and distress increases. Detention in these circumstances may be, strangely, a right and proper way to protect people from harm.

Alternatively, a shortage of community services or perhaps, with staff shortages and pressure on beds and services, a culture may develop where it is easier to detain than to give the sort of support people have a right to.

Ideally further research would reflect on the Human rights approach we took with the review. There is almost no research around coercive treatment that uses a human rights framework as the basis of the research. We would like to see future research designed that seeks to decide if a person’s human rights are enhanced by certain interventions or not; those balances between the right to life and health compared to rights to liberty and independent living and so on.

Now onto detention and things like the time we are detained for.

You will hear elsewhere at this conference about research by the Mental Welfare Commission into the length of short term detentions; following this we have proposed pilot projects into the length of such sections.

Regarding Compulsory Community Based Treatment Orders we are also aware that the evidence of their effectiveness is very weak, with contradictory findings from different studies. Some studies in Scotland show they provide protection for life and reduce days spent in hospital while others show no effect. We suggest that more research is carried out into them to help determine future policy, again looking at their value through a human rights lens, including our economic social and cultural rights, but also trying to work out why they have been rising, how they can be best used and who they may or may not be effective with.

We also think we should make sure that CCTOs will ensure access to recovery-focussed, trauma-informed, community-based services and that from the beginning there are revocation strategies built in to ensure they are being used for the right reasons and to best effect.

I am going to finish with what may seem to be throw away comments but which are important to me and maybe relevant to this discussion.

It is often those we love most who are witness to the worst of our distress and are most affected by it. I will never forget my brothers voice cracking with anger when I last talked of how I looked forward to stopping my medication. He said that each time that happened the whole family was on standby for the time I finally succeed in killing myself: those around us need listened to and respected and supported.

I constantly meet people who are told that have the capacity to decide whether to live or die when they are seeking help and that this is their choice. It is utterly insulting and depressing.

Sometimes I wonder at our definition of mental disability and feel for those who are dismissed as ‘just’ being unhappy and told to take a walk or run a bath when they cannot imagine living another moment and sometimes I am aghast when people say they get better treatment from the police when they are in crisis than from the NHS. I am fed up with hearing stories about people told to go home at three in the morning with no money in their pockets, freezing temperatures and despair in their hearts. When they are returned to A&E by the police or ambulance a couple of hours later, we should hang our heads in shame.

And although our freedom and our rights are crucial issues I think just as crucial a rights issue; needing just as much debate and legislation, are the people who die, end up homeless or in prison or just alone and scared and isolated because they are denied support and care and services. This is fundamental too. The rights we lose; the horror we experience when society seemingly couldn’t care less what happens to us.

On a completely different note. Once I lived in a toxic relationship, and getting sectioned was a frequent occurrence. Now, although I am on a CTO, I haven’t been in hospital for ten years. I now live with a family where respect is a given, as is laughter and giggles and cuddles. I walk by the sea with the curlews, seals and terns. I go to Argyll and Bute Rape Crisis and the difference in approach is incredible and liberating.

I work, I write books. I go to Jeans Bothy, which is a mental health and wellbeing hub in the nearby town where I can be me without hiding my reality. I have found a life where, everyday I feel treasured. Maybe my medication is vital but so is Wendy my partner, James and Charlotte the twins, and Dash the dog who sleeps on my bed. Most people in my situation do not have anything approaching this. Why not?

It is no wonder we end up sectioned when our lives are close to unliveable. We may need advance statements, or care plans, depot clinics and tribunals but above all we need to shift our focus to say “How do people like me find friendship and love? How do we get to find security in where we live, or glimpses of beauty when we walk out the house, someone who wants to kiss us every day, enough money to afford a treat, or to heat the house?”

Having this in my life means I am less convinced when I say out loud that “I want to die” whenever no one is near me. I get my jag every two weeks; its irritating, I sometimes get fed up with the nurses and sometimes I like them but they are a tiny part of my life.

The laws, services and policies we obsess with about for our freedom and rights are important but equally important, is when we recognise that even though I miss the feeling of colour in my life, I have everything I could ever want and that other people could have similar.

That did not come from the NHS; it came from my partner, my family, my friends, people believing I had the skills to work and speak. It came from knowing when I get home I will probably sit on the beach and look out at the mud flats with a book in my lap, the breeze on my face, crows picking at the seaweed, herons standing still and a home I look forward to returning to. Such things as this are just as important as the formal help I am meant to be given. With this the can of petrol or the train tracks become less of an obsession and I can dare to dream of something different altogether.