

Psychiatric Rights Scotland

Mental Health (Scotland) Bill

Psychiatric Rights Scotland is an organisation which aims to protect the human rights of people in psychiatric settings in Scotland. It is made up of service users and carers, most of who have experienced or witnessed very bad experiences in psychiatric care.

It is a member of the Cross Party Working Group for Mental Health at the Scottish Parliament. It has a website on Facebook organised by a service user. This submission has been drafted by carers with input from service users.

We have serious concerns about the Mental Health (Care and Treatment) Scotland Act 2003 (the 2003 Mental Health Act) and the following is a précis of these concerns:

1. Psychiatric drugs have serious side-effects and do more harm than good
2. The United Nations is recommending an end to compulsory treatment for human rights reasons
3. The admission process to hospital is not robust, with treatment before a court hearing
4. Mental Health Tribunals are very unfair and lead to wrong conclusions
5. The Millan principles (principles of good practice) are ignored including carers' views
6. The World Health Organization (WHO) recommends that Electro Convulsive Treatment (ECT) should only be given with informed consent
7. People with autism and no mental illness should be excluded from the 2003 Mental Health Act
8. Complaints are very rarely properly investigated

1. Psychiatric drugs have serious side-effects and do more harm than good

1. In one important 2013 study, patients stopping antipsychotics had more than double the chance of achieving "functional recovery" than those continuing to take the medication.
2. Serious long term antipsychotic effects are routinely ignored by psychiatrists.
3. Antipsychotics cause specific harm to people's brains, for example: Brain Tissue Changes and Antipsychotic Medication [Puri BK (2011)].
4. Evidence of long term antipsychotics doubling the mortality rate of elderly patients and causing Parkinsonism.
5. Thomas Leonard has created a website researching side-effects.

http://www.thomashoskynsleonard.co.uk/med_correspondence.htm

6. There is overwhelming evidence that psychiatrists are increasingly working to a single treatment paradigm i.e. drugs and these are over prescribed e.g. there has been a 50% increase in the number of patients prescribed antipsychotic drugs in the last 10 years (ISD data).
7. There is good evidence of beneficial effect for some patients with severe and enduring mental illness such as schizophrenia and bipolar disorder, but drugs should not be the only treatment.
8. It is unfortunate that DSM has expanded from 160 diagnoses at outset 60 years ago to 550 different conditions now. This means that 20% of the population qualify as having a mental disorder.
9. Drugs get used for conditions they should not be, such as autism, dementia, learning disability and many cases of depression.

2. The United Nations (UN) is recommending an end to compulsory treatment for human rights reasons

1. UN Convention on the Rights of Persons with Disabilities (CRPD): Since the UK has ratified this Convention the Scottish Parliament is required to take account of it when it legislates.
2. On 4 March 2013 Juan Mendez, the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment addressed the Human Rights Council of the UN and in his address made the following statement: "The CRPD offers the most comprehensive set of standards on the rights of persons with disabilities and it is important that states review the anti-torture framework in relation to persons with disabilities in line with the CRPD. States should impose an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshock and mind altering drugs for both long- and short-term application."
3. It is doubtful whether there should be an absolute ban on all involuntary treatment. However, Parliament should study closely Article 12 of the Convention on the Rights of Persons with Disabilities. Article 12 is concerned with legal capacity, something to which insufficient attention has been given in the 2003 Mental Health Act and by those implementing it. An individual with capacity has the right to refuse treatment.

3. The admission process to hospital is not robust, with treatment before a court hearing

1. A patient has less rights than a criminal in comparison.
2. Andres Breivik of Norway killed 77 people yet was able to stand up in court and lucidly defend his actions publicly. He was able to examine the evidence

and get excellent legal assistance to show that he should not be put in a psychiatric institution.

3. A person who has committed no crime can be detained and treated for 28 days under a Short Term Detention Certificate (STDC) based on a single interview behind closed doors with a psychiatrist without legal representation or assistance from friends and family.
4. When compulsory measures are used the psychiatrist becomes the "police" taking and interpreting the witness statement, the "prosecution", the "judge" and the jury. While others i.e. the Mental Health Officer (MHO) and a General Practitioner may be involved this not in an adversarial way as occurs in the criminal justice system and what results is a lack of cross-examination or quality control.
5. Psychiatrists are as faulty as the rest of us and will make mistakes as do the police and Members of Parliament but the difference is that psychiatrists are able to operate and remove liberty without effective governance.
6. For a STDC there is no way of making sure an interview with the MHO and contact with the family takes place.
7. The only way to improve the system is to introduce a professional who can defend the rights of the patient and hold the psychiatrist and the MHO to account.
8. The treatment before a court hearing can actually make a patient worse, since the side-effects of medication can appear to be symptoms of a mental illness.
9. The Council of Europe have recommended that before someone is placed or treated in a psychiatric institution a fair and public hearing must take place.
10. The ECHR has ruled that no individual shall be deprived of his liberty on the basis of unsoundness of mind unless, at a minimum, he or she has reliably been shown to be of unsound mind.

4. Mental Health Tribunals are very unfair and lead to wrong conclusions

1. There is no "equality of arms" between the patient and the treating psychiatrist and therefore too many people are subject to compulsory treatment.
2. There is a presumption that the patient has a mental illness.
3. A patient is likely to be heavily sedated and cannot properly represent themselves.
4. The National Health Service (NHS) controls all the documentation. Thus they have more time to prepare and can also withhold information unfavourable to them.
5. The constitution of the tribunal (a lawyer, psychiatrist and usually an NHS employee) is such that the diagnosis of the treating psychiatrist is less likely to be challenged than if they were drawn from the public.

6. They are held in secret and can therefore not be scrutinised.
7. Witnesses are not on oath and are thus more likely to make misleading statements.
8. The Limited Review of the 2003 Mental Health Act (published in 2009) describes the quality of legal representation as poor.
9. Tribunal members are paid about £400 per day. It is possible that it might be in their financial interest for people to be on compulsory treatment.
10. The tribunal too often functions as a tick box exercise where judicial process is seen to be done but is not really fair or proper. Usually it seems to boil down to the opinion of the Responsible Medical Officer which the tribunal team will rarely go against unless the patient can afford to get another psychiatrist as an alternate expert. The cross-examination process is quite feeble and clinical judgements such as how an opinion on lack of capacity was made are not tested.

5. The Millan principles are ignored including carers' views (these are a set of principals enshrined in the 2003 Mental Health Act)

1. There are vast publications claiming stakeholder involvement but when it occurs it is usually tokenism.
2. Many of the submissions to PE1494 (a petition to parliament from us about amending the 2003 Mental Health Act) are from carers whose views have been ignored.
3. These principals are unenforceable. Claire Muir, a service user, took out legal action against the NHS. One of her claims was that the Millan principles were not followed. The sheriff dismissed the case without allowing her husband to speak.
4. The principle of participation (Service users should be fully involved, so far as they are able to be, in all aspects of their assessment, care, treatment and support) is not followed in any way in some cases.
5. The principle of benefit (Any intervention under the Act should be likely to produce a benefit for the service user) is not followed in many cases since in the 2009 Julie Ridley survey, 50% of all users said compulsion was not right for them.

6. WHO recommends that ECT should only be given with informed consent

1. The 2003 Mental Health Act permits ECT to be given to a patient who resists or objects to the treatment. However, since the passage of the Act, the WHO has recommended that "If ECT is used, it should only be administered after obtaining informed consent".

2. The UN Special Rapporteur on torture, etc. has recommended that states should impose an absolute ban on non-consensual electroshock, i.e. on non-consensual ECT.
3. The safeguard relating to ECT requires a designated medical practitioner to consent before it can be given against a patient's will. That this safeguard is worthless is evident by considering the experience of Claire Muir. She was seen by a designated medical practitioner but she claims that he had made no attempt to assess her. Fortunately she was put into the care of a different responsible medical officer who revoked her compulsory treatment order since he could detect no identifiable psychiatric disorder. There is no guarantee that a designated medical practitioner will carry out a proper assessment of the patient when required to do so under the Act.
4. According to the National Institute of Clinical Excellence (NICE) some who have been given ECT "report feelings of terror, shame and distress...". The information from NICE in its consultation document would appear to make clear that involuntary ECT falls within the definition on inhuman and degrading treatment provided by the European Court of Human Rights in the 2002 case of *Pretty v UK* (para 52) in that it can cause intense mental suffering. Such treatment is prohibited in all circumstances by virtue of Article 3 of the European Court of Human Rights.
5. It is no excuse that those who authorise or practise ECT claim that in most cases it will be in the patient's best interests to be given ECT even though it is against his or her will. It is certainly not always in the patient's best interests.
6. Proponents of ECT claim that modern methods ensure that patients no longer suffer permanent memory loss. That assertion, I suspect, would be impossible to substantiate. Also, even proponents of ECT do not claim that it is 100% effective in curing severe depression. Further, in 2010 Richard Bentall and John Read co-authored a literature review on the effectiveness of ECT. Their conclusion was that "the cost-benefit analysis of ECT is so poor that its use cannot be scientifically justified".
7. The Scottish Government states that there has been no ruling from the European Court of Human Rights that says ECT breaches any article (of the European Convention on Human Rights). This does not mean that an action raised there would fail. Note should be taken of the fact that in North America Dr Peter Breggin has acted as an expert witness in successful ECT malpractice suits. In one of those there was a settlement of more than \$1 million.

7. People with autism and no mental illness should be excluded from the Act

1. Several carers of people with autism do not wish them to be treated with medication.
2. Fiona Sinclair has set up a group called Autism Rights to achieve this.

3. Christine MacVicar appeared on the front page of the Sunday Post and fled to Spain to save her son's life.
4. Medical conditions need to be ruled out, before psychiatrists are involved. The DSMs all say this and also the British Medical Journal's best code of practice.
5. GPs just reach for the prescription pad and have little or no training in how to investigate conditions that present as mental illness.
6. There are a number of publications on this, not least "Emergencies in Psychiatry," by Basant K Puri.
7. The lack of training in nutrition, with a total emphasis on drugs, means that deficiency states are routinely missed. Our poor soil, because of artificial fertilisers, translates to deficient food and grazing, which affects humans and animals alike. From B vitamins to beriberi, they all affect our thinking. Someone who is chromium deficient can give an instant response.
8. There is a landslide of research on environmental toxins affecting neurology.
9. Autism is a neurodevelopment disorder and it makes no sense to include it in the mental health act as a mental disorder or as billed on some of the detention forms a mental illness. It would be like calling all cases of cerebral palsy a mental disorder. It seems very odd to me that conditions such as autism and Down syndrome are managed perfectly well by paediatricians - but once adulthood is reached the adult is left in the hands of a psychiatrist.

8. Complaints are very rarely properly investigated

1. A victim only has 12 months from the date of the alleged violation to bring a legal Human Rights challenge. This is a tall order for a sectioned patient who has to recover from their ordeal, especially as it can take months or years for necessary disclosures and documentations (suppressed favourable medical reports, etc.) to be obtained from the authorities.
2. The complaints process is characterised by defensiveness, a lack of willingness to find fault or even bring about positive change.
3. The Mental Welfare Commission have only published reports on anonymous people and not on any person who can challenge their findings. They very rarely criticise a professional.
4. Ill-treating a patient and making a false statement on a document are offences under the Mental Health Act but no-one has ever been charged. The police use corroboration rules as an excuse to delay investigations indefinitely.
5. The Scottish Public Services Ombudsman will not investigate complaints since they have a one-year timebar and have been through the Mental Health Tribunal Scotland (MHTS) system.
6. It is very hard to find a human rights lawyer to effect a civil legal challenge.

7. No-one has ever investigated tribunal transcripts.
8. The Scottish Legal Complaints Commission has a one-year timebar.
9. The General Medical Council will classify complaints as level 2 which means it is up to the NHS to investigate. 10. The NHS will not own up to errors for fear of litigation.
11. The Scottish Social Services Council will not investigate complaints against MHOs.
12. The MHTS will not investigate previous decisions.

Recommendations

1. The Mental Health (Care and Treatment) Scotland Act 2003 should be repealed or drastically amended to meet the needs of carers and service users.
2. An investigation should be carried out of those people who have had bad experiences under this Act and a formal apology should be given by the Scottish Government to those people affected.

**Psychiatric Rights Scotland
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