MHB002-Individual

Senedd Cymru | Welsh Parliament

Bil arfaethedig – Datblygu'r Bil Safonau Gofal Iechyd Meddwl (Cymru) | Proposed Development of the Mental Health Standards of Care (Wales) Bill

Ymateb gan: Unigolyn | Evidence from: Individual

I am a medical professional but not a psychiatrist. I have worked as a senior medical manager in Wales and through the Royal Colleges representation, at strategic level in the Welsh Government advisory structure. I have a lived experience of 25 years of two family members in the mental health system in Wales.

I am uncertain what further considerations will be given to this proposed Bill. If there is an opportunity to present oral evidence to, for instance, the Health and Social Care committee I would be very happy to contribute.

Enshrining overarching principles in legislation

Question 1: Do you think there is a need for this legislation?
Can you provide reasons for your answer.

I believe there is an urgent need for reform of the legislation relating to the treatment of mental disorders. Whether the proposed legislation is sufficient for this purpose is doubtful. It would seem that the proposed Welsh legislation is an adaption from the recommendations from the review of the Mental Health Act performed by Sir Simon Wessley, past President of the Royal College of Psychiatrists.

The current regulatory environment is primarily designed around protecting society from people with mental illness rather than helping these individuals and society to integrate and coexist better. It allows Psychiatrists and the extended system of health and social care to manage the individuals it deals with. However the outcomes for individuals are frequently very poor. There is a danger to these individuals that the treatment they receive can cause them more harm than benefit. This breaches the principle of “First do no harm”, enshrined in the Prudent Healthcare policy.

Internationally there is a major change happening in thinking to move away from compulsion and institutionalisation of patients with mental health

problems. This was recognised by those performing the UK Review but they have chosen to maintain the present emphasis on compulsion and detention. There is a 20 fold difference in rates of detention in European countries with the UK being one of the highest and the rate increasing. The UK is in danger of being left behind as this movement progresses.

The changes in the proposed legislation moves a little in this direction in terms of the purpose and sentiments expressed. However if the safeguards set out in the current legislation were actually implemented in practice then there would barely be a need for the changes proposed. The current system is very adept at using legislation for its own purposes to maintain the status quo and the power relationships within it. This may be contrary to the welfare of patients.

There is a serious likelihood that the wording in the proposed legislation will not result in any fundamental change in the way these services are delivered. The beliefs of staff who have been trained and inculcated in the existing culture will be difficult to change.

Question 2: Do you agree or disagree with the overarching principles that the Bill seeks to enshrine?

I agree with the overarching principles but they are insufficiently bold. The legislation as drafted can be interpreted as representing minor changes at the edges of the existing modes of practice and will be insufficient in terms of producing fundamental change.

Specific changes to existing legislation

A. Nearest Relative and Nominated Person

Question 3: Do you agree or disagree with the proposal to replace the Nearest Relative (NR) provisions in the Mental Health Act 1983 with a new role of Nominated Person?

Can you provide reasons for your answer.

I strongly disagree with this proposal.

I agree that the subject should be able to appoint a Nominated Person to advocate for them but this should be in addition to the Nearest Relative, not instead of.

In many cases it is family members who are initially concerned about a person's behaviour and mental health, and relatives are frequently involved in seeking

help at a time of crisis. This, understandably, can result in stress, tension and discord within the whole family. The subject often misinterprets the family involvement as interference and disloyalty. This is evidenced by the frequency with which family members are the subject of violence from the person in crisis. This proposal would represent further exclusion of the family. The presumption should remain that the family has the subject's best interest at the fore, unless objective contrary evidence exists.

It is not appropriate for the person in crisis to make long lasting decisions about their relationships or their representation. Family members are often the only people who know and understand the person's pre-morbid personality and the circumstances that may have resulted in crisis. In the long term it is often the family who are the only consistent part of a complex set of relationships over the following years. Professional staff enter and leave the team trying to help the person, but the only people with an enduring caring relationships are family members.

There is a lot of published data and evidence showing that the outcomes for people who enter the Psychiatric system are greatly improved if family relationships endure.

For these reasons it is very important that family are kept engaged with the person and the process in order that they can continue to have a caring relationship and advocate for them.

There already exists a well established mechanism for a person to remove their Nearest Relative if they want to do this.

There needs to be an extension and professionalisation of independent mental health advocates. At present their role is seen as unimportant by the system and indeed their rights and effectiveness are very limited. One way of improving their status would be to ensure that their views be given prominence in Mental Health Tribunals.

There is a clear need for stronger and more informed advocacy. People facing other circumstances where their liberty is at risk, i.e. the criminal justice system, are given a clear understanding of their rights, are advised and accompanied by a solicitor during questioning. A solicitor is familiar with all the rules used in the criminal justice system and can support that person. A person in crisis facing loss of liberty through the psychiatric route should enjoy the same, if not greater, rights and protection. They are patients, not criminals.

A person and their family faced with the disaster of a mental health crisis and meeting the psychiatric system for the first time is at a huge power disadvantage. They are overwhelmed by the new lexicon of terminology, the unfamiliarity with what is going to happen and huge concern and worry. The current advocacy for the patient, and their family, is completely inadequate, and often absent. What advocacy is available usually comes from the voluntary sector and does not enjoy professional status within the system.

It would be far preferable to have professional advocates fully trained and funded centrally, that can advocate effectively for people who are taken into the psychiatric system, advise them of their rights and ensure that they are dealt with fairly. From our experience this does not happen.

I suggest that the Nearest Relative status should be maintained but that in addition there is a Nominated Person, who has the same powers of holding the system to account as in the judicial system. The Nominated Person could be a professional advocate, which might include legal professionals, be associated with the voluntary sector, or be a friend or family member trusted by the person.

B. Changing the criteria for detention, ensuring the prospect for therapeutic benefit

Question 4: Do you agree or disagree with the proposal to change in the criteria for detention to ensure that people can only be detained if they pose a risk of serious harm either to themselves or to others?

Can you provide reasons for your answer.

The criteria for detention should be clear and specific. The definitions of serious risk are currently undefined. This means that there is huge latitude for the mental health professionals to make arbitrary and non evidence based decisions. These decisions are often based on the risk they perceive, not to the person or others, but to the system. This results in huge variability in decision making from place to place and time to time, and influenced by any recently publicised events relating to people with mental disorder. One shocking event is likely to cause a ripple of increased risk aversion within a locality.

The level and quality of risk that a person and their circumstance represents needs to be more clearly identified, and agreed amongst a defined group that should include those advocating for the person. At present that decision making is exclusively made by Psychiatric and social services personnel and this is one of the main sources of conflict. Often these decisions are being made by personnel who have scant knowledge of the patient, their history and family circumstances.

So the criteria should include a statement relating to the quality and quantity of the risk identified, not merely a poorly defined concern within the system.

Question 5: Do you agree or disagree with the proposal to change in the criteria that there must be reasonable prospect of therapeutic benefit to the patient?

Can you provide reasons for your answer.

I agree entirely that people should not be detained unless there is a prospect of a therapeutic benefit. There should be clear guidance as to what 'reasonable' means in this regard, and this should relate to the objective evidence that exists for benefit from Psychiatric intervention in a setting of detainment. The professionals need to be challenged to bring forward what evidence they have to support the continuation of this practice. At present detainment is used for the prevention of risk to society primarily and there is little evidence of benefit to the person.

If there is no prospect of therapeutic benefit to the person in detention then they should only be able to be detained within the remit of the criminal justice system. Their detention within the mental health system would be an artifice and morally indefensible.

As previously stated there are many jurisdictions internationally where the direction of travel is to abandon detention as a means of managing mental disorder. This emerged from the Review findings performed by Sir Simon Wessley, where a decision was made to continue with a policy of detainment but to modify it to make the practice less unacceptable.

It could also be argued the requirement of a therapeutic benefit would make the current utilisation of the Deprivation of Liberty Safeguards illegitimate for those diagnosed with a Mental Disorder, as opposed to people who require safeguarding due to an enduring condition such as dementia, brain injury or learning difficulties. This is because a DOLS authorisation does not incorporate any therapeutic intent, merely a mechanism of managing a difficult problem and subjectively perceived risk.

C. Remote (Virtual) assessment

Question 6: Do you agree or disagree with the proposal to introduce remote (virtual) assessment under 'specific provisions' relating to Second Opinion Appointed Doctors (SOADs), and Independent Mental Health Advocates (IMHA)?

Can you provide reasons for your answer.

The current system of Second Opinion Appointed Doctors (SOAD) is not intended to give a true second clinical opinion of any sort regarding diagnosis and treatment. Its entire stated purpose is to ensure that the first opinion is not vulnerable to challenge. As such it does not matter whether it is remote or in person, it is of no value to the person in detention, its only purpose is to protect the system.

It is extremely difficult to get a truly independent second clinical opinion. One of the reasons for this is that were it to differ, no-one would then know what course of action should be taken.

The SOAD system is also a mechanism whereby (early) retired consultant psychiatrists can continue to earn professionally without being exposed to the rigours of front line practice.

The SOAD system is no safeguard against poor decision making and abuse within the system. To make this a remote exercise will be neither of benefit or harm.

D. Amendments to the Mental Health (Wales) Measure 2010

Question 7: Do you agree or disagree with the proposal to amend the Measure to ensure that there is no age limit upon those who can request a re-assessment of their mental health?

Can you provide reasons for your answer.

I support this proposal. There is no cogent reason whereby there should be an age restriction on this right.

Question 8: Do you agree or disagree with the proposal to amend the Measure to extend the ability to request a re-assessment to people specified by the patient?

Can you provide reasons for your answer.

I agree with this proposal. Anyone with knowledge and an interest in the person in crisis should have the ability to question those exerting control.

General Views

Question 9: Do you have any views about how the impact the proposals would have across different population groups?

No

Question 10: Do you have any views about the impact the proposals would have on children's rights?

No

Question 11: Do you have any general views on the proposal, not covered by any of the previous questions contained in the consultation?

The current legislation relating to mental health clearly requires reform. There is a need to incorporate a wider range of views than those expressed by Psychiatry. There are alternative perspectives which are gaining traction in the UK and abroad that are not incorporated into the existing legislation nor in the proposed Bill. These include the views of the British Psychological Society, the views of the Evolutionary Psychiatry Special Interest Group within the RCPSych. and those that advocate against the pharmaceutical approach to treating mental health problems.

The criminal Justice system is endowed with many checks and balances to mitigate against abuse of power and miscarriage of justice. This includes separation of powers between legislators, police, CPS, jury, judiciary, sentencing guidance, appeals systems, parole and probation. There is also a requirement for rights to be read and applied including the right to remain silent, for interviews to be witnessed and recorded, and professional representation and defence of the accused at every stage.

In contrast the procedures in existence within the mental health system for depriving people of liberty are without automatic protection of the rights of individuals. Psychiatry sets the rules, gathers the evidence, makes diagnoses,

imposes treatment without consent, controls all aspects of the course of the deprivation of liberty and determines the length of detention as they wish. They also control the application of personal constraint including the use of drugs, ECT and physical restraint during the process. They apply a wide range of coercive controls. If the person recognises the risks inherent in speaking openly and remains quiet, they are said to be displaying defensiveness to obscure their symptoms. Staff on wards are trained to make and record their observations and to infer symptoms from witnessed behaviours, without seeking alternative explanation from patients. Once recorded these become 'truths' which the patient cannot challenge. Ultimately patients are deemed to be lacking insight unless they agree with their diagnosis and acquiesce to the regime they are subjected to. A whole range of impenetrable double binds and Catch 22s. There is little prospect of meaningful reform while the imbalance of power that currently exists persists. That the recent national Review is chaired by a past President of the RCPsych in itself demonstrates the level of control.

The governance relating to Deprivation of Liberty Safeguards (DOLS) is worse. The number of applications for DOLS authorisations has gone up exponentially over the last decade to 250,000 per year in England. To put this in context the care home population in England is 408,000.

The term Safeguards is a misnomer and the mechanism is routinely used by staff to exert control. The various safeguards that are meant to apply, least restriction, assumed capacity, assistance to make decisions, specific decisions at specific time, are all routinely and deftly inverted.

The bar set by the threshold criteria is extremely low. The 'Mental disorder' criterion includes almost every diagnosis in the ICD lexicon including stress, anxiety and skin picking as qualifying conditions. The Mental Capacity Assessment comprises a stranger with variable background experience, making a short visit. Their interview is not witnessed and often the subjects are ill informed about its purpose or ramifications, nor is personal support made available. In many instances families are excluded and paid representatives used. Within the DOLS regulations the role of the Nearest Relative is dispensed with.

The Best Interest Assessment, which is undertaken by another member within the same team, is almost universally found in favour of applying the DOLS Authorisation. To expect a person to meet another for the first time with little knowledge of them or their history to determine what is in their best interest is difficult to accept. Nor can they provide a truly independent view when relying on other members of the applying team for information. Family are often excluded from the process. It so easily becomes an algorithmic exercise which

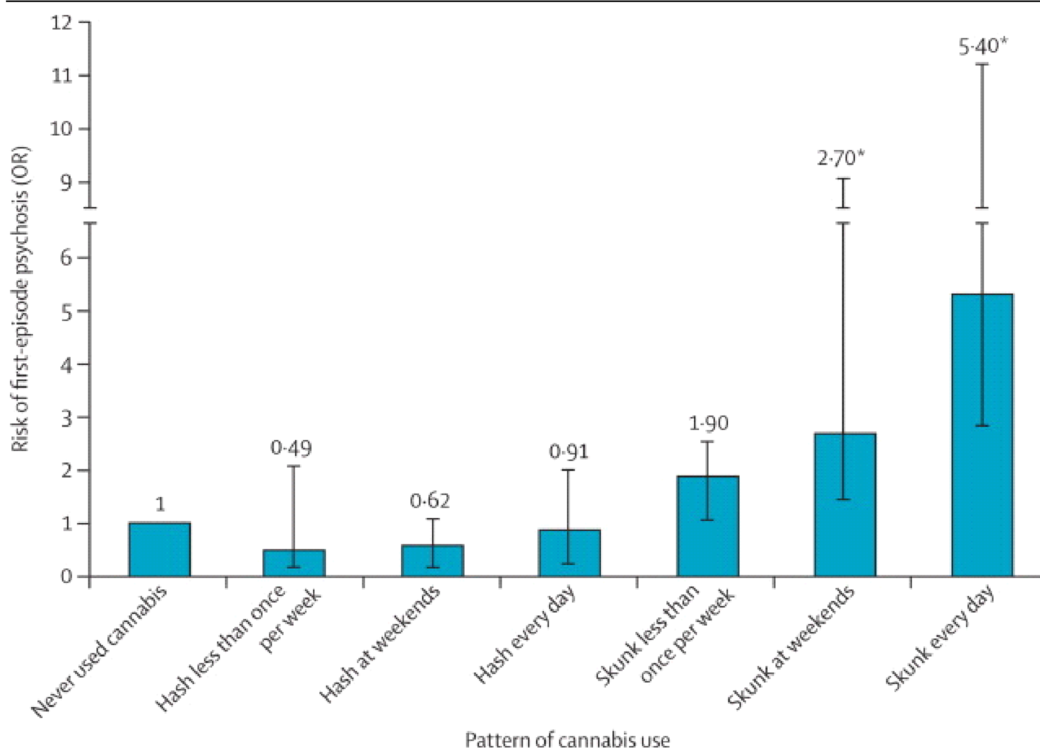
can only be challenged by the subject applying to the Court of Protection. A daunting process for those in great distress or crisis.

If the six criteria proscribed are affirmed by the Best Interests Assessor and their colleague performing the Mental Capacity Assessment deems that capacity is lacking, then the Supervising Authority is obliged by statute to authorise the Deprivation of Liberty. Follow on authorisations are usually then given without a further assessment of capacity.

Data from Wales shows that in almost all local authorities the Best Interests Assessment concludes that a Deprivation is deemed in the person's interest 100% of the time. There is no biological variable that can be correct 100% of the time.

The request for a DOLS Authorisation is made by the managing authority, which is, in the great majority of circumstance (83% 2015), the manager of a private sector care home. The managers of these homes are required to have a NVQ level 5 as their sole qualification. Thus large tranches of public money are transferred to private care homes, via a facilitating local authority mechanism. Many homes are owned by hedge funds and corporate organisations. There are clear conflicts of interest that influence decision making.

A significant omission from the proposed legislation is a strategy to address the prevention of serious mental illness. It is now well established that high THC cannabis use, particularly in early adolescence is the single most important cause of psychotic illness with daily use confer a greater than 5 fold risk.



While the war on the supply of drugs has been largely lost, the market can still be influenced. Although supply cannot be prevented, demand can be influenced by an effective campaign of education in schools, social and traditional media, as well as other points of access to young people. Some of the NHS mental health budget could make a significant impact in this endeavour.

It should be noted that Mental Health in Wales is very well resourced receiving around 11% the total NHS budget. This is the greatest proportion in the UK and per capita amongst the highest spend in Europe. Despite this Wales has about half the number of Consultant psychiatrists and half the trained nurses per capita compared to Scotland. It also has the lowest incidence of community contacts between patients and community staff and a low number of in-patient beds. This needs explanation.