Response to Scottish Government Mental Health Proposals

I thank the Scottish government for this opportunity to comment on its proposals regarding the mental Health Act. I responded as an individual to petition PE01494, which concerned the issue of whether the Mental Health Act is compatible with Human Rights law. I wish my submission to this petition (linked below, in which like others I detail medical and abuses committed under the Mental Health Act) to be considered as part of my response to the present government consultation, as indeed the Petitions Committee promised.

I would also like to respond to Question 2 on the Named Person proposals. The proposal to reduce the role of the Named Person seems to me the most significant of the Scottish government’s proposals, if not indeed the main purpose of the review. The proposals on the Named Person are a grave human rights concern, as the government surely knows that under the ECHR, detained patients must have the right to appeal their detention. Yet the government clearly hopes to reduce the representation of patients in the Mental Health system, by making sure the (usually drugged) patient’s Named Person, who may represent their last hope, can not effectively represent the patient.

Further, evidence presented at Tribunals to support a diagnosis of mental illnesses usually comprises behavioural allegations, and often the Named Person has the crucial background to the accusations against the patient. However, under the new proposals, Named Persons will need permission to apply to Tribunals to bring appeals - or even take to take part in Tribunals - when patients are sectioned. Often the right of appeal will, effectively, vanish.

This part also proposes that Tribunals should be able to refuse the Named Person’s access to documentary evidence. This would in many cases make it all too easy to obstruct the patient’s right to obtain and challenge the evidence against them, as even happens under the existing system. Alternatively, the Tribunal or the MHO will be able to simply resist and interfere with the Named Person nomination in the first place (something else that happens already, as in my submission shows), and appoint someone suggested by the MHO – that is, someone favoured by the sectioning bodies! This is against known principles of justice. These proposals will increase the power that Tribunals already possess to ensure that the will of the RMO and MHO shall prevail, even in cases where the evidence is dubious, wrong or fabricated. With the Named Person (and any evidence of impropriety) kept at arm’s length, Tribunals and RMOs will be even more unaccountable than they are already.

By way of explanation the government says “Concerns have been expressed about the automatic entitlement of a named person to be involved in Tribunal and Court hearings relating to a patient”.

In the ‘easy-read’ outline of the proposals the proposal to neutralize the role of Named Person is presented as if it were designed to meet patient concerns. Tellingly, it is even addressed directly to patients! For instance, “This will mean that a named person will no longer automatically receive information – sometime confidential information - about you prior to a Tribunal hearing”. http://www.scotland.gov.uk/Resource/0044/00443294.pdf.

This framing is disingenuous, as what else it might ‘mean’ (to the detriment of patients and their human rights) is not pointed out. While the proposals are framed to appeal to patients,
the main beneficiaries will surely be section-minded psychiatrists and MHOs with poor
evidence. The real concern seems to be that the Named Person is presently able to challenge
(on behalf of a forcibly incapacitated patient) false and misleading statements made to
Tribunals by the MHO and RMO. This ability will be drastically reduced as Tribunals or the
MHTS will be able to choose which appeals are to be heard. As evidenced in the rest of this
submission, serious and evidential challenges can be made to the integrity of the information
submitted on detention documents. But under the proposals it will be easy for Tribunals (in
collusion with the MHO as the government even suggests) to simply decline such awkward
and embarrassing challenges.

I can testify with absolute certainty that the dangers I allude to above are very real – simply
because, even without the government proposals, such interference within the Tribunal
process already happens. I have been involved in at least half a dozen Tribunals and in at
least four of them the evidential challenge brought by, or on behalf of, patients was thwarted -
not by analysis or by the weight of opposing evidence, but by using ‘tricks’ to bury it. My
own submission to Petition PE01494 details one such shocking story. In one of the other
submissions a solicitor was not allowed to represent a patient, the excuse being cited that it
was ‘not in his best interests’ (incidentally, that patient now has antipsychotic-induced
Parkinsonism).

What the government proposes will therefore make present medical and legal abuses
seem legal and legitimate.

The particular abuses that I refer to above are not untypical of what was received in the
individual responses to Petition PE01494,
http://www.scottish.parliament.uk/GettingInvolved/Petitions/mentalhealthlegislation.

The Petitions Committee asked for evidence from individual submitters to back up their
concerns. It received links to various medical papers detailing harm from compulsory drugs,
as well as a catalogue of specific complaints about the functioning of the Mental Health
Tribunals. However, the Committee acknowledged neither this medical evidence nor the
volume and gravity of the abuse allegations. Instead, it moved to close the petition citing
the viewpoint of the professional organisations (who of course bear responsibility for the
alleged abuses!). Strangely, it did not put any of the evidence to those professional
organisations who were responding as if such abuses do not happen at all, let alone
frequently. Despite being in possession of a substantial body of evidence already submitted
that supported the individuals’ allegations, the Committee then publicly responded in such a
way as to ignore those concerns and portray them as merely ‘emotional’. At the same time,
it appears to have invented medical ‘evidence’ it claimed was submitted by the medical
organisations consulted. Certainly virtually nothing was published in this regard – all the
medical evidence was supplied by the campaigners. The Committee thereby reversed the
true picture regarding the evidence submitted. In order to forestall a repeat of this evidence-
ignoring exercise, I respectfully request the government to publish in full all professional
responses as well as the individual ones.

As the Petitions Committee promised to pass our submissions on to the government, it is
worth stressing here what was submitted in the areas of

(i) medical harm from forced psychiatric treatment,
(ii) Human Rights legislation and

(iii) evidence of abuses.

(i) Dr Thomas Leonard, in his submissions and website, has provided a broad view of the evidential picture regarding harm from psychiatric medications. His website [1] links both to the wider nature and scale of the problem and to more detailed medical evidence. 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. This was, notably, “the first long-term follow-up of a randomised trial comparing people who stopped taking antipsychotics with those who continued their treatment”. This fact (the emphasis is mine) is even more damning than the outcome. I very much doubt that this is news to the entire health committee, but please take note: **Serious long term antipsychotic effects are routinely ignored by psychiatrists.**

Also linked on Dr Leonard’s website are studies that confirm the emerging (but long suspected) picture of antipsychotics causing specific harm to people’s brains, for example: Brain Tissue Changes and Antipsychotic Medication [Puri BK (2011), http://www.ncbi.nlm.nih.gov/pubmed/21721911]. Evidence of useful alternative therapies is also discussed.

In my own submission I included evidence of long term antipsychotics doubling the mortality rate of elderly patients [2], and causing Parkinsonism [3]. These are acknowledged by medical researchers – indeed there are 300 medical studies concerning or mentioning ‘drug-induced Parkinsonism’. They are also acknowledged by psychiatric professionals (except when deliberately asked the wrong question!). The link to study with double the deaths in the elderly came from the Psychiatric Times. The increased risks of diabetes and strokes from antipsychotics is also well known.

Finally, Fiona Sinclair of Autism Rights has submitted copious and very well researched information detailing all of the problems arising from the (mis)treatment of Autism as a mental illness; this has highlighted the (frankly, amazing) absence of statistical information on people on the autistic spectrum treated under mental health law (and indeed on people treated in the mental health system as a whole); rather disgracefully, a considered response to this kind of information has been lacking so far, but the government now has the opportunity now to put this right.

It should be clear from all this that the information submitted has so far been deliberately downplayed, because while the Petitions Committee claimed that medical evidence had been submitted that showed there was no problem, there was not a single mention of Autism in the (supposedly) medical responses!

(ii) Petitioner Hunter Watson raised issues [4] relating to Human Rights legislation and mental health law; the absence of an oath in Tribunals, the presumption of mental illness (imagine asking a jury if the accused 'continues to be guilty' !) and the implications of European legislation. It is noteworthy that his points remained mostly unanswered. The main response has been that is no Case Law. This is a very poor response, partly because Human Rights ethos - and legislation - demands a pro-active stance towards prevention and
protection, not a reliance on legal hurdles placed in front of victims. The response is also logistically disingenuous, because a victim only has 12 months from the date of the alleged violation to bring a legal Human Rights challenge – this would often be 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.

(iii) Finally, all the individual submitters gave accounts of abuses that took place in the cases they were involved with. I wish to draw your attention to the summary of complaints below, which we requested be seen by the members of the Petitions Committee (a request that was refused by the clerk). This amounted to about a hundred complaints contained within the submissions, as is easily verified by a simple scrutiny of the submissions.

http://www.scottish.parliament.uk/GettingInvolved/Petitions/mentalhealthlegislation

SUMMARY OF INDIVIDUAL COMPLAINTS SUBMITTED TO PETITION PE01494

All cases: patients wishes not taken into account, completely ignored.
Almost all cases: family wishes completely ignored.
Almost all cases: patients drugged almost immediately.

There were multiple occurrences of the following complaints:

Misleading evidence given to Tribunals (at least 10 complaints)
Tribunal ignoring or dismissing contrary evidence (at least 10 complaints)
Tribunal accepting innuendo (at least 7 complaints)
Breaking the main provisions of the Act
Apparent errors in law and/or tricks to overcome legitimate challenges Mental Health act
Criteria challenged but not tested
False claims made to Tribunals

The following were all reported at least twice:

Preventing witnesses appearing for patient and named person
Tribunal documents not produced
Denial of symptoms of medication

Reason for section not given, medical reports favourable to patient suppressed or not-admitted to

Diagnosis later contradicted

There are other extremely serious complaints, like one patient never being examined before being sectioned, yet being unable to get redress afterwards; and a medical Professor warned by health board that if he presented contrary evidence for a patient, his contract would not be renewed.

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All of this is easily enough for any ordinary, reasonable person to see that there are grave problems in the Mental Health system – the only way to deny there is a problem is not to acknowledge any of the evidence in the first place; a feat that the Petitions Committee performed. If the government is sincere about consultation and indeed Human Rights it must do a lot better than the Committee, and acknowledge and respond to the evidence submitted to it in response to its own questions, including the abuses contained in the responses to Petition PE01494.

Finally, I would to make a final comment on what I believe should happen. A Mental Health Tribunal is not ‘like a court’ (a requirement of the ECHR) simply because a court would take a grim view of being misled, whether accidentally or not; whereas in the mental health hearings I have attended, the Tribunals regarded as ‘reliable evidence’ whatever the MHO and RMO said, even after it had been factually refuted by patients or their representatives. Any serious review of the functioning of the Mental Health Act must address this problem by (i) making RMOs and MHOs genuinely responsible (i.e. in reality) for their claims. (ii) There must also be a proper and regular feedback mechanism from patients, and public scrutiny of actions taken in response. (iii) Lastly, the government must address human rights questions arising from compulsory mental health treatment proactively, in accordance with the ECHR.

Sincerely

Walter Buchanan


[2] Mortality after 3 years of antipsychotic treatment was about double that without medication

(i) “Drug-induced Parkinsonism (DIP) secondary to antipsychotics and other dopamine antagonists is common and can be clinically indistinguishable from idiopathic Parkinson’s disease (PD)”


(ii) “Drug-induced Parkinsonism must always be suspected when parkinsonian symptom like rigidity, tremor, or postural instability appear in patients receiving drug treatment. …The main causative drugs are antipsychotic, other neuroleptic drugs, and calcium-channel entry blockers”


(iii) “Drug-induced parkinsonism (DIP) …Initially reported as a complication of antipsychotics, it was later recognized as a common complication of antidepressants, and…. Despite being a major health problem in certain populations, it seems to be frequently overlooked by the medical community”


(iv) “All antipsychotics, including atypicals (except clozapine) may produce parkinsonism”


NB there are 300 research papers referencing “Drug-induced Parkinsonism” in the above medical database http://www.ncbi.nlm.nih.gov/pubmed

[4] Petitioner submissions:
http://www.scottish.parliament.uk/GettingInvolved/Petitions/petitionPDF/PE01494.pdf
