PE1494/V

Submission to Public Petitions Committee
PE01494

Walter Buchanan, 24 February 2014

All the professional groups would have us believe that patients receive clear benefit from enforced drugs; the Royal College of Psychiatrists adds that petitioners have not presented evidence of human rights violations; however a Lancet study reported in the Psychiatric Times [1, 2] found that mortality risk was doubled in 3 years for dementia patients prescribed antipsychotics, as is routinely done in hospitals. Further claims not based on reality are that evidence is 'tested' in Tribunals, and that evidence under oath is not necessary due to S318 (this only provides potential legal comeback against outright lies). In the Tribunals I describe below, the RMO and MHO were allowed to mislead and distort facts with impunity; their claims were accepted without question, even when substantial evidence brought refuted them. The much-heralded 'principles' that are supposed to ensure good practice were completely flouted. This would appear to show that an oath is needed, not just about 'the truth' but 'the whole truth'; as well as a genuine method of enforcing it. Those who suggest waiting for 'case law' seem to have no knowledge of how Tribunals operate in practice, and do not seem to 'get' the very concept of human rights.

I was Named Person for an elderly but very fit lady diagnosed with dementia (Miss P) that I knew very well. I was surprised when she was sectioned, as she had already been assessed as NOT being a risk by the social care team, which included the MHO and the psychiatrist (RMO). As the RMO explained to me, a family member had put 'immense pressure' on them to place the patient in hospital. This 'pressure' was not disclosed by the mental health team to the Tribunals (nor apparently to the independent psychiatrist who referred to Miss P's 'paranoid' suspicion that there was collusion); though I was obliged to point it out, the Tribunals never acknowledged it. Of course, the family member was entitled for their view on the patient's welfare to be given full heed; there was however the matter of the patient's wishes, rights and the legal process [Human Rights alert - if patients had genuine human rights, this information would not have been suppressed]. The breach by the system of the patient's human rights became undeniable when my appeals on Miss P's behalf resulted in me being removed as NP and replaced by the same family member. The system therefore knowingly removed the patient's right of appeal - a right that was already being improperly opposed. Moreover, every one of the supposed 'safeguards' of the system knew this.

The decision to section Miss P being counter to their own recent judgment, the RMO and MHO were obliged, in order to justify the Section, to exaggerate and distort the information they already had.
For the STDO application, which I appealed against, the 'risk' submission was highly misleading. A 'suicide risk' was presented, even though everyone in the care team knew Miss P lightly said something every day about 'jumping in the river' without meaning it. Occasionally someone reported this at meetings - at which I and the RMO and the MHO were present - and it was met with smiles; there was never any discussion of this supposed 'threat'. It was also claimed that while in care homes, as a former nurse Miss P put patients at risk trying to help them, a fabrication that was withdrawn. Another allegation that she had "gotten into cars with strangers who she feels can help" was also a distortion; while in a care home for respite, Miss P had slipped out of the back door to go for a walk. The 'stranger' was a uniformed male nurse from the home who had gone after her in his car to fetch her back. The way that feelings were falsely attributed to the patient ("strangers who she feels can help" - the patient could not have said this, as she was not in distress!) and the repeated use of false plurals ('cars, strangers') to exaggerate, were part of a disturbing pattern. The other two incidents given to indicate 'risk' were similarly misleading – reactions to stressful and painful situations due to avoidable care lapses, with the background removed to SUGGEST symptoms of mental illness. These incidents had already been evaluated by the team as NOT indicating risk. The 'cars with strangers' incident was claimed to indicate a new 'escalating risk'. These misleading accounts were also used to boost the criterion on the patient having a mental disorder.

Another criterion is "the patient's ability to make decisions about the provision of medical treatment is significantly impaired". The STDO application referred to her being in 4 different care homes for respite in

the last few months (in fact there were only 3 homes, one was visited twice) which it was claimed showed impaired decision making. The guidelines on capacity expressly state that it is NOT a matter of whether the patient's decisions are agreed with, but whether the patient can take them by making sense of the available information. But not only had the patient made the decisions to go in and come out, they clearly did make sense. She came out of two nursing homes - already noted by the MHO and others as being 'unsuitable' - and tried to stay IN two suitable care homes. Essentially she had not come out of ANY suitable care homes voluntarily. In addition, she constantly expressed a wish to go into sheltered housing, and the idea of hospital was consistently bottom of her list. The less restrictive housing options would also address any risk. She had also readily agreed she would attend psychological counselling if it were offered. The problem was that Miss P's decisions though in her own interest were no longer acceptable to the team.

Though I had brought the appeal my factual challenges to the misleading information on 'risk' were ignored in the Findings. The Tribunal simply re-iterated the non-existent 'suicide threat' and repeated the misleading facts of some of the other 'risks' - as if I had submitted nothing! The eight-page challenge I submitted received barely a mention in the one-page findings. My protests about the persistently misleading information submitted by the RMO were not mentioned either.

On the patient's decision-making capability, the convenor said I hadn't brought any medical evidence to counter the 'medical evidence' of the psychiatrist. In fact the RMO had not brought ANY medical evidence. Factual distortions of the social work record coming from a psychiatrist were counted as 'medical evidence' - but my factual evidence which contradicted these claims was not.

Under the 5th criterion 'necessity of detention', I had brought confirmation that prior to the section, the MHO had indicated she favoured the sheltered housing option as it was a less restrictive one. She had also said that the patient's suggestion of paid overnight help was a good idea. The Tribunal had been informed, in writing, that the patient was both able and willing pay for this herself.

The Tribunal's response to these last questions may have been in contravention of the legislation. The convenor told me that a CTO application would go ahead irrespective of the result of the present Tribunal, (the MWC later told me this could NOT be the case), and that the present tribunal could not consider such matters but to 'bring it to the CTO hearing'. However, the 'matters' were brought in CHALLENGE to the legally binding criteria of 'necessity' of the detention. If the convenor was right then certain evidential matters are not in fact open to challenge as is claimed [Human Rights alert!]. This verbal dismissal of one of my appeal grounds with questionable 'advice' did not appear in the Findings.

Another impropriety was that the evidence given in support of this 5th criteria was illegible, despite my written request for a translation. A legible bit claimed the patient "did not want to stay in a care home" - untrue, as noted, as the RMO now conceded. The fifth criterion was declared 'met' by default and by a false claim.

The next CTO application was just as misleading. The 'risks' claimed to Miss P from the same incidents were now reduced to weaker suggestions of risk to her health or welfare from 'distress', even though these incidents were responses to known and preventable, stressful situations. The alleged suicide 'risk' was now the only specified risk but the ward staff clearly had no knowledge of it; they often didn't know where she was. An unlocked, out-of-view back gate from the hospital's garden enclosure (which Miss P was allowed to hike round unsupervised for long periods) was only 'fastened' with a single piece of old string and the exit path led out via a railway platform in about five minutes walk; the RMO and MHO evidently did not themselves believe their claimed suicide 'threat'.

For the criteria on whether the patient's ability to take decisions about medical treatment is impaired, the RMO and MHO stopped referring to the patients' actual decisions taken; perhaps as a simple examination of them showed this criterion was not met. What replaced them was a series of patient portraits or sketches – isolated, usually one-line quotes that were supposed to indicate something but did not. For example, "Miss P is unable to weigh up the difficulties and risks she faces at home". Apart from the fact that the patient wanted into two of the care homes to relieve her distress at home, the prejudice suggested by this

statement is striking; the RMO and MHO were not able to specify these "risks" themselves, but a patient is supposed to demonstrate to them that they can weigh them up! Ironically Miss P and I had complained previously to the RMO about another psychiatrist's innuendo and inaccurate 'sketches' of her.

A new 'issue' of road safety was produced, but before the section Miss P walked miles most days on her own with no concerns expressed. She had been independently witnessed when out during the section as being safe crossing the road (pressing the button, looking both ways etc), despite having to take drugs. Yet another written opinion reversed for the section was that she now apparently needed 'nursing care'.

I apologize for 'shouting' now, but please WITNESS how the much-heralded PRINCIPLES are EASILY SIDESTEPPED. To the question "To what extent does the proposed care plan reflect the wishes of the patient", the answer should have been 'ZERO extent'. The follow-up question was: "If any of these wishes have not been respected, why not?" The patient's views were WELL KNOWN – hospital was consistently the last thing she wanted – but these didn't even make it on to the form. The question is clear - but the response was more little patient sketches and quotes (selected from an interview where she was upset) that gave the IMPRESSION the patient's views were unreliable or incoherent. I found this professional disregard for the guidelines on capacity shocking. The next question "What alternatives were considered and why were they not deemed to be workable?" was also ducked. Instead, the now familiar misleading narrative falsely implied the care homes option was not workable as Miss P kept coming out of them; also there was no mention of Sheltered house, Bed and Breakfasts and paid overnight help. These patient preferences were only cited at the end of this long report as being 'MY' viewpoint when they were the PATIENT's expressed past and present WISHES.

At the hearing, the CTO application foundered on the technical point that the application by the RMO/MHO was made in advance of the second psychiatrist's report; i.e. they had taken the outcome for granted. This was regarded as possibly prejudicial and could result in the refusal of the CTO application- although the error could be waived if the Named Person agreed. I considered this carefully but as I DID consider it prejudicial, I could not agree the error should be waived. My concern was borne out by the second psychiatrists' report which showed that the information he had been given by the MHO and RMO had been selective and misleading. And so the CTO failed.

After this, nothing was normal again. Despite the refusal of their CTO, the RMO and MHO controversially moved immediately to re-detain the patient under S44 of the Act (this needs EXPLANATION as S44 seems to expressly PROHIBIT this). The patient had of course assumed she was free to go home and was now upset, and wanted me present at the interview. It was well known that she had written to the doctors over a year before authorising me to speak to them on her behalf – partly as another psychiatrist had badly misrepresented what she had said. Meanwhile I had been subjected to indignant criticism from both the patient's advocate and the curator ad litem, and a discussion followed. The MHO claimed I 'would only upset her' as I 'had been arguing'. The 'safeguards' were attacking the patient's Named Person! For being the only one concerned about the patient's rights and wishes. The patient was pulled by the hand down the corridor, crying. The advocate (who had started the 'argument') went in with her instead. The advocate later told me that 'she was only interviewed when she stopped crying'. Were these apparent further breaches of the patients rights' justified anywhere in the Act? Much seems made up on the hoof. [Human Rights alert! Criminal suspects have the right to have a lawyer or someone else present, and of course to have their rights explained]. So another STDO was obtained, possibly in breach of the Act.

I was aware that my evidential challenges were not going down well when I myself had begun to feature in misleading little portraits by the MHO and the curator ad litem (two 'safeguards') in the official documentation. Ominously, my solicitor told me he had heard that consideration was being given to finding 'a way' of removing me as Named Person [Human Rights alert!] and that they had considered claiming the patient had not the capacity to nominate me, but decided it couldn't be done that way.

I appealed against the new STDO, but I was in for a surprise. At the appeal Tribunal hearing, the tribunal announced my nomination as Named Person was invalid because of the papers weren't signed - it was an 'oral nomination', they said, and so my appeal was 'misconceived'. But the papers were signed properly

initially - they seemed to be claiming the collapsed CTO nullified the NP nomination which seems very doubtful. It was claimed that the Tribunal had picked up this 'anomaly' but they had a good while to chat off-tape to the MHO/RMO about my application before I was allowed in, something else that would not happen in a court. The patient nominated me again without hesitation and I soon resubmitted my appeal.

Meanwhile, despite the patient having being sectioned due to 'escalating distress' and 'anxiety' the RMO had refused requests for psychological input or help for the patient and had stopped returning my calls. Such help IS in the NICE guidelines and we have it on the authority and submission of NHS Scotland/Scottish Government on 21 Jan that such a referral MUST be available for behavioural and psychological symptoms in dementia. Taking the practical advice of the first Tribunal that on assessment I needed professional medical evidence on this ignored issue of psychological factors, I had helped the patient visit a psychotherapist to obtain a hopefully quick medical assessment of her. The psychotherapist did not assess patients that quickly and sensibly preferred six visits (involving some initial therapy) to get to know a patient before assessing them. The psychotherapist's final assessment said that emotional wellbeing and being treated with respect were essential for Miss P and improved her concentration, relaxation and motivation and she had also seen for herself that these conditions simply did not prevail in the ward. It concluded that although the patient had dementia she responded to good stimulation and communication and this made her also more accepting of her dementia, and hospital was therefore the wrong place for her. These visits comprised relaxation therapy and other psychotherapeutic techniques (mostly talking therapy, including singing as the patient was known to enjoy this). Often unhappy after a night in the wards, Miss P thoroughly enjoyed those morning visits and was almost unrecognizable for a time afterwards. This good news did not however go down well with the RMO and MHO, and the repercussions swiftly took a surreal turn.

A few days before the STDO appeal hearing the MHO applied to have me removed under Section 255 which allows for removal of Named Persons who are 'unsuitable'. This was surely not intended to be used for scuppering legitimate appeals, but the Tribunal to remove me was pointedly scheduled just before the hearing of my now burgeoning appeal; obviously so that the latter would fail - there had been two previous attempts to unseat me as Named Person, without any implied suggestion that I was unsuitable!

There is only brief space to describe this long tissue of unsupported innuendo and untruths from the MHO - which was moulded into shape and lapped up by a willing 'Tribunal', which was not worthy of the name. A 'menu' of 12 mostly ludicrous claims about me were presented, and for most of which no evidence was brought. The Tribunal simply picked 4 from the menu that it would choose to believe. The CLAIMS of the MHO were taken automatically as 'evidence' (which wasn't 'tested' in any way, as complacent bureaucrats claim) but rather 'gobbled up', with my challenges being ignored. Even the snippets the MHO brought contradicted her claims but these were also 'evidence'. The Tribunal freely ignored and mixed up evidence and witnesses to suit - before announcing it's decision on the 'weight of evidence', having seen none. With my removal, the right of the patient to oppose her detention had been removed.

I had raised several concerns with the MHT (another 'safeguard') in advance about the apparent unfairness of this hearing but received no serious reply. There was clearly no possibility of dealing with witness evidence for all the vague innuendos on the menu, in the hour (sic) scheduled for this Tribunal. In the event, witnesses allegedly for the MHO had been invited to the hearing (but not asked to confirm anything), but my witnesses were not allowed in, including the qualified psychotherapist whose credentials the MHO was allowed to scorn.

The first item on the 'menu' was a new one, sprung verbally on the day [Human Rights alert!], and was a pure invention. Early on the patient had asked to see details of incidents that were being held against her [Human Rights alert!]. I enquired with the MHO and she raised no objection; indeed it was she who got me the address for the patient. I myself asked if there would be any problem in me going through them with the patient as she asked. The MHO said the RMO would decide any capacity issue when the records were sent (they never arrived). There was not even a possible issue of impropriety. But the MHO now said I had told her I "wanted access" to the patient's social work records and asserted it was "for myself". She gave no indication why she should think this; nor did the Tribunal ask for one. She further told the Tribunal she

was “made aware of” a request for the records that had been signed by the patient but completed by “someone else.” But she already knew I was helping the patient complete the forms! Had her ‘suspicions’ been genuine, the item would have been on her written submission six days earlier.

In the MHO’s version of the incident of the aforementioned ‘argument’ (worded so as to blame only me), she claimed the clerk asked her to intervene to stop the patient’s ‘distress’, and also that I had unduly ‘pressured’ the patient into agreeing I should come in with her to the interview. Of course no evidence was brought for any of this. The RMO had ‘confirmed’ - seemingly irrelevantly - there had been ‘an argument’. But the Tribunal soon knocked these rather unpromising ingredients into shape, finding that:

“the MHO …. had been asked by the Tribunal clerk to intervene as the patient was becoming distressed because the named person was trying to persuade her to allow him to accompany her to a meeting with the RMO”.

This is a TREBLY false account of the evidence given – the Tribunal (which is headed by a senior lawyer) MIXED UP the two incidents, allocating the clerk to the one that mattered and altering the REASON she allegedly said she intervened; then falsely attached the ‘evidence’ of the other witness (the RMO) of the first incident to the second - where she was not even present. And then, it ‘accepted’ it’s own concoction.

The only item with a factual basis was the complaint that I had helped the patient obtain psychotherapy. Though the RMO had said she had no medical objection to the ‘talking therapy’ that the patient enjoyed, it was presented as a significant concern, as if it would interfere with her treatment (that she was not having).

The MHO repeatedly falsely claimed the patient had paid for all of the sessions even though I had told her the patient had paid for one session at her own insistence as a compromise as the psychotherapist thought if I paid for it all there could be a suggestion of manipulation. The MHO’s own ‘bank enquiries’ showed her claim could not be true, but the Tribunal accepted it anyway.

The claims made here of the RMO, MHO and others at various points, that the patient didn’t have CAPACITY (no matter what was proposed) indicates a widespread and deep-rooted problem; the guidelines on assessing patient capacity are being widely flouted. Even a layman such as I knows that capacity is not ‘all or nothing’ but is specific to the treatment or procedure proposed, and that consent to a procedure should be determined by the relevant specialist; in this case the RMO had said herself she was not qualified to judge the issues I had raised regarding psychological help. The guidelines expressly say that patients should NEVER be labelled as having no capacity because of a diagnosis, and they should be given every help to achieve it, not placed in a position of further disadvantage.
The guidelines would do well to add that patient capacity - of ALL things - should never be used as a tactical device to ward off legitimate challenges.

Please note in passing that I once stood in at a Tribunal as a lay representative of the Named Person of another sectioned patient who had been diagnosed with having paranoid delusions, and on that occasion I was ejected from that Tribunal for repeatedly questioning the psychiatrist’s inability to specify a single delusion held by the patient. That action was claimed to be ‘disruptive’. Combining my two eye-opening experiences, I would say that while the petitioner rightly points out the deference of Tribunals to the opinion of the psychiatrists, he might also have added that they seem to regard ‘evidence’ as being whatever the MHO and RMO say - medical or not - and regardless of whether it is contradicted by the evidence of the patient or their connections. How many psychiatrists, lawyers, politicians, professionals and government-funded rights groups does it take to see that if there is so much ‘informality’ that the RMO and MHO can safely write whatever they like, then the Tribunal CEASES TO BE “COURT-LIKE”, and patients are therefore, according to European law, being UNLAWFULLY DETAINED?

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[1] http://www.psychiatrictimes.com/login?referrer=http%3A//www.psychiatrictimes.com%2Fmortality-antipsychotic-use-alzheimer-disease-0

[2] http://www.ncbi.nlm.nih.gov/pubmed/19138567