Chrys Muirhead

Mental Health (Scotland) Bill

"Sometimes, when people are unwell, they may have to be detained in hospital or have treatment against their will. But they still have rights. We all have human rights, and mental health law contains special rights and safeguards to protect people." Mental Welfare Commission for Scotland

Unfortunately it was my family's experience in February 2012 that the safeguards contained in the Mental Health (Care and Treatment) (Scotland) Act 2003 weren't safe.

A family member who became an inpatient of an hospital's IPCU on 1 February 2012 knew the Act well as they were studying it for a BSc honours sociology 4th year dissertation at University, and therefore knew their rights (they graduated this summer 2014). As primary carer and named person I also knew what their rights and mine were. However our knowledge and experience carried little weight when they were detained under the Act in a locked seclusion room with no toilet or water to drink, for hours at a time, medicated with Midazolam.

The Mental Health Act is based on a set of 10 Principles and at number 7:

"**Respect for carers** - Those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account"

I contend that I was not accorded the respect as prescribed in the Act and was not given timely or appropriate information. For example on 1 February 2012 they received a serious hand injury and I wasn't told about it until 3 February on a phone call. I then had to ask a doctor in the IPCU to examine it on Saturday 4 February, after attempts by nurses to keep me from visiting until Monday 6 February. I had to ask the ward Junior Doctor to examine my relative's hand and then asked him to arrange an X-ray at St Andrews Hospital which I also attended, on 6 February where it was confirmed that they had breaks to their right hand at the joints. (my relative is a pianist)

I contend that I was bullied and intimidated by 5 nurses in the dining room of the IPCU on Saturday 4 February 2012 at around 2pm for trying to see them and photograph the hand injury and bruising. The nurses refused to let me see my relative and said they didn't want to see me yet when I got home later there was a message on my phone from my relative asking me to visit, so I went back up at 6pm as the nurses wouldn't let me in until then. I was not allowed to take a photo of their swollen broken hand and bruising to their face and arms, when I eventually saw them at 6pm 4 February 2012. The bruising was due to restrained face-down on 1 February 2012 in the ward by 3 nurses.

My relative is asthmatic and has had 3 collapsed lungs in the past so this procedure was very risky to their health and then they transported them in

only their bare feet and underwear, escorted by 2 porters into a minibus and up to the IPCU. I witnessed this and was told by the Mental Welfare Commission, on the phone, that there were no complaints about the IPCU. Therefore I assumed this meant that they were in a safe place. I didn't know they used a locked seclusion room and had never heard of this before in Scotland's psychiatric system of which I have over 40yrs experience. I was shocked and started making enquiries around the country, phoning other psychiatric hospitals to ask if they used locked seclusion rooms. I never found another place that did use them.

Furthermore regarding "**Respect for carers**", I informed Fife Council social work managers about the issues in the IPCU and later found out that the Adult Protection Investigation focused more on me rather than on the nurses' behaviour. I was accused of causing "psychological harm" when my relative was having their human rights abused in the IPCU. The Fife Council Mental Health Officer leading the Adult Protection Investigation questioned a psychiatrist and a CPN about my character while my relative was a locked-in patient of the IPCU. I was accorded little respect from any of the statutory agencies and made complaints to all of them, including to the Fife Police who were involved in the investigation. To which I received an apology, that it was a "learning point". I got a similar response from Fife Council social work services. It seemed that disrespecting a relative and carer was a matter of not having enough learning or education.

Named Person

I was primary carer and Named Person for my relative when they were an inpatient of the IPCU yet the RMO, a consultant forensic psychiatrist, waited a week before meeting with me to discuss my relative's treatment in the IPCU. At this first meeting the RMO told me that "people without capacity don't require advocacy". I told him that he was mistaken. Firstly my relative had capacity although they were mentally distressed and required caring treatment. Secondly all patients detained under the MH Act are entitled to advocacy, more so if they lack capacity. That first meeting with the RMO set the scene for the rest of our engagement. My relative asked me to advocate for them at clinical meetings in the ward and so I had face-to-face engagement with the RMO at close quarters.

It wasn't pleasant and on one occasion he mentioned a medium secure unit in Edinburgh, and the State Hospital at Carstairs, both hospitals that he had worked at. This seemed like a veiled threat, that if my relative didn't comply or conform then he may end up in either of these institutions. (I knew of other patients who had ended up there from the hospital) Threats don't work with me and this made me more determined to advocate for my relative and align myself with their wishes, regardless of what I thought might be best. For the best advocacy is independent advocacy. Unfortunately in Fife the advocacy isn't independent because the service is managed by an English learning disability service provider.

Mental Health Tribunal
My relative appealed their 28 day detention. They had been put straight on to the 28 day section on 1 February and wasn't informed about this until 2 February. By the time their appeal was heard at the Tribunal they were back in the open acute Ward, under a different psychiatrist and they were appealing a CTO. They had been forcibly medicated when in the IPCU with Haloperidol, 25mgs, firstly by injection in the locked seclusion room, which caused them to fall over and have agitation, restlessness. I had to instruct the nurses to give them Procyclidine for side effects. Therefore when my relative got to the Tribunal they were sedated and had been traumatised by the abusive treatment in the IPCU. I advocated for them at the Tribunal and they also had a solicitor present who unfortunately was not experienced and kept referring to a reference book regarding procedures.

The Tribunal psychiatrist instructed my relative's psychiatrist to give them a diagnosis/disorder label because up to that point there was no psychiatric "label" in their notes. The point being that if a person has been detained and forcibly treated then they should have had a mental disorder diagnosis for this to happen. Otherwise for what reason would an RMO be authorising the locking in of his patient in a seclusion room with no toilet or water to drink? What sort of treatment is that, for a person who is mentally distressed and has had suicidal thoughts? Is this appropriate professional practice? With no mental disorder diagnosis in the notes I wonder how the use of force can be justified. (in fact I contend that this sort of treatment is dehumanising and can never be justified, mental disorder diagnosis or not)

My relative's appeal was not upheld and they were put on a CTO then given a bipolar disorder diagnosis. However the CTO was revoked by their psychiatrist approximately 2-3 months later as they had been discharged at the beginning of April 2012 into my care. They live with me. And the Haloperidol drug/medication was tapered over a five month period with agreement by the psychiatrist and with my support. They got off all the psychiatric drugs by August 2012. However the flashbacks from the dehumanising treatment in the IPCU continued for quite some time and even now to think on what was done to them was not pleasant. They have been disabled by the psychiatric treatment and is not able to do paid work.

Independent Advocacy
I have touched on this already and would add that it was difficult for them to access an advocate in the IPCU when they needed one. They weren't always available and if they were then it might not be the same person twice which wasn't helpful having to repeat the story. They have made attempts in the first week or two of being in the IPCU to speak to the police about an assault they claims were made on them by a nurse in the Ward on 1 February 2012 but the appointments were cancelled by the psychiatrist on more than one occasion. They also spoke out about other abuses and these have still to be investigated properly. Now that my complaint against NHS Fife, in respect of the seclusion room and the transfer in bare feet and underpants, has been upheld by the Scottish Public Services Ombudsman it means that we can consider how to proceed with criminal matters.

In 2009 the local Fife independent advocacy services lost out at a tendering process to the English learning disability service provider. I campaigned at the time with the local groups at Scottish Parliament and still believe it was a mistake on the part of Fife Council and NHS Fife to award the advocacy contract to a service provider, moreover based in England. The Scottish Independent Advocacy Alliance does not recognise the Fife advocacy project as being “independent”. I contend that it has further disempowered the mental health service user voice, and that of carers, resulting in more risks to psychiatric inpatients and less accountability in terms of implementation of the MH Act, and its effective monitoring. If patients and carers are being silenced and disrespected then the result will be human rights abuses and targeting of whistleblowers.

Advance Statement
My relative had an advance statement written down prior to becoming a detained inpatient of the IPCU. They have a more detailed on now and so do I, in which we both have written that we don’t want, under **any circumstance**, to be treated in the future in Hospital. It would be far too risky for either of us. In February 2012 their advance statement was not adhered to and the RMO told me that he preferred Haloperidol to Risperidone as a drug of choice. There was no consultation and the decision was his. Haloperidol is an older antipsychotic which is harsh in its side effects. They were forcibly injected with it after their dirty protest and what the nurses did to them afterwards. They were forced until they would take the drug orally and voluntarily. Which eventually they did when they had made them conform. On 28 February 2012 they got out of the IPCU and into the Ward. I felt that they had broken their spirit and it meant I had to keep a close eye on them in the open ward.

I continued to raise complaints whenever I witnessed unprofessional nursing behaviour or anything untoward. I was bullied by 3 different male nurses in the Ward during March 2012. One shut a door in my face, it was the male nurse who my relative alleged assaulted them on 1 February 2012. Another came up close and leaned over me where I stood and I had to tell him to move back. Yet another confronted me on one occasion, was aggressive in manner, and I later found out that he was one of the male nurses who had cornered my relative in a back room of the Ward on 1 February 2012 when my relative’s hand got broken. Even later on I heard that this nurse had emigrated.

I witnessed other issues in Ward in March 2012 which I complained about in Emails to senior NHS Fife mental health managers, copied in to Mental Welfare Commission staff and Scottish Government mental health division senior civil servants.

Mental Welfare Commission for Scotland
I phoned the MWC on 1 February 2012, twice from the Ward after I had been put in a side room by a nurse and left there. This was after seeing my relative face down on the floor being restrained after I’d come back into the ward having made a complaint about a male nurse who had behaved inappropriately with me that morning. That same male nurse was the one who my relative alleged assaulted them when I was out of the ward collecting a

holdall of clothes from our house, about a half a mile from the hospital. The timing of this is as follows: the male staff nurse at about 10am had put his arm around me without my permission in front of my relative and others. It was inappropriate behaviour as I didn't know the man and it was over-familiar. It concerned me and so I decided to bring it to the attention of the clinical services manager who I knew. I told her about the incident at about 12.15pm up at her office which was in another building on the grounds. Then I went home to pick up the holdall. I'd told them I was coming back at 2pm. They hadn't been admitted at this point to the Ward as a patient because the assessment with the Junior Doctor hadn't been completed.

When I came back at 2pm I entered the Ward with the Junior Doctor who also was coming back in to see a female patient, he said, who had the police in with her in the ward. And we both saw my relative face down on the ground, 3 nurses holding them down. I was put in a side room and left there. When I'd left the ward earlier my relative had been sitting resting in the patio area. Later I got the full story from them. The nurses tell a different story. I believe my relative.

I phoned the MWC from the room I was put in, spoke to the Fife worker who I knew, telling him what had happened and that I'd been left/abandoned in a side room. Not long after a doctor and a nurse came in to speak to me. Then later in the afternoon I again spoke to the same MWC worker after hearing that my relative was getting transferred to the IPCU and was told by them that there was no negative feedback from patients or carers. I then saw them getting taken out in their underwear and bare feet, drugged up, at about 4pm on 1 February 2012, I thought they were going to a better ward environment. I trusted that they would be well looked after. I didn't know their hand was broken or about other issues at that point because no-one told me.

By the 4 February 2012, after being bullied by 5 nurses in the IPCU dining room I realised that something was far wrong. The fact that there was no negative feedback at the MWC was no indicator of good practice or of caring treatment. From that moment on I was on my own, it seemed, and they was at risk. I didn't know about the seclusion room until the 8 February and hearing about the dirty protest. Fortunately I had a good friend who shared the visiting with me. She is a pastoral visitor at Cupar Baptist Church and has known my family since 1990. She stood with me and I stood with my relative.

I realised after my relative's IPCU inpatient stay in February 2012 that the Mental Welfare Commission for Scotland is not there for patients and carers who are being subject to bullying and intimidating treatment in psychiatric settings. Their helpline was of no use to me and on occasion the phone was put down on me when I asked for help. I would describe the MWC as "wise after the event". I was looking for help **during** the event. But I was on my own and had to rely on family and friends to stand with me. At times it was a desperate situation, as a mother, to be in. I wouldn't wish it on anyone. The feelings of powerlessness and of injustice at times was unbearable.

Conclusion
I want to see Mental Health Act safeguards that are safe, and which work to protect patients in psychiatric settings so that they are free from unreasonable treatment and human rights abuses.

I want to see carers, and mothers, respected for the person they are and the role they have in the patient's life.

I want to see NHS health boards being held accountable for what happens in psychiatric settings behind closed doors.

System failure is not the fault of patients, carers or families.

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