Mental Health Strategy for Scotland : 2011 - 15

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Responses to selected consultation questions

Q1 What additional action could be taken at national level to help implement the Dementia Strategy?

A1 The Scottish Government should Educate, Exhort and Enforce.

1.1 The importance of appointing attorneys while capable should be emphasised.

1.2 The right of an adult to refuse treatment should be publicised and attention drawn to the GMC consent guidance.

1.3 The public as well as health professionals should be made aware of the risks in giving psychoactive drugs, particularly antipsychotic drugs, to people with dementia.

1.4 Those responsible for the care of dementia patients should be made aware that "there shall be no intervention in the affairs of an adult (with incapacity) unless the person responsible for authorising or effecting the intervention is satisfied that the intervention will benefit the adult and that such benefit cannot reasonably be achieved without the intervention" (2000 Act, s 1)(4)

It should be made clear to medical practitioners that this implies that they must not prescribe psychoactive drugs for the benefit of care home staff, and also that care home staff are not absolved of responsibility merely because they have persuaded a medical practitioner to prescribe a psychoactive drug to a care home resident whom, in their opinion, presents challenging behaviour.

1.5 Those with a responsibility for adults with dementia should be made familiar with the Human Rights Act and relevant Convention rights particularly the following:

- the absolute right not to be subjected to inhuman or degrading treatment;
- the right to liberty;
- the right to respect for private life.

The implications of the Human Rights Act and those particular rights should be made clear.

1.6 Those caring for adults with dementia should be aware that even those with severe dementia have feelings and do not stop trying to make sense of the world. Some of their beliefs will be manifestly untrue and may be described as delusions. It should be appreciated that cognitive behavioural therapy is unlikely to dispel those false beliefs (eg that a long dead parent is still alive) and that the administration of an

antipsychotic drug is unlikely to cause such symptoms of psychosis to disappear.

1.7 Publicity should be given to the fact that some care homes manage to look after residents with dementia with little or no use of antipsychotic drugs. The Saga magazine of July 2010 provides two examples of such homes together with an outline of how they manage to keep their residents as contented as might be expected in the circumstances. Such strategies should be widely adopted with care. Home managers having the prime responsibility for ensuring that residents are not left sitting around with nothing to do for most of the day, possibly locked in their rooms or restrained in some way from getting up and walking about when they feel inclined.

1.8 Care home inspectors should report on the level of prescribing of psychoactive drugs in care homes, including sleeping pills, which can be prescribed in order to ensure that residents do not require attention from staff during the night.

1.9 The Dementia Strategy at section 72 suggests that "psychoactive medication should be a last resort and not the first approach to challenging behaviour." Inspectors should confirm that other approaches have been tried before medication is used.

1.10 A recent report from the Office of the Inspector General for the Department of Health and Human Services in the USA revealed that about one million residents had been prescribed antipsychotics in a way that violated government standards for their use. For example, residents were on a drug for too long, or at too high a dose.

1.11 According to Richard Bentall in his prize winning book "Madness Explained", studies have shown that "no additional clinical benefits were obtained for doses equivalent to more than about 350 milligrams of chlorpromazine a day, a much lower dose than was commonly used in routine practice". The same studies provided clear evidence of a simple linear relationship between dose and side effects – the higher the dose the more likely it is that patients will experience side effects that are severe and very distressing ... Despite advice to the contrary --- psychiatrists continue to treat many of their patients with bizarrely high doses of neuroleptic drugs" (p501) (Neuroleptic = antipsychotic)

1.12 In October 2009 a report into the use of antipsychotic medication was published. The

report, which had been commissioned by the Department of Health and written by Professor Sube Banerjee recommended, at section 4.1, that, if used at all, antipsychotics should be given to people with dementia "at the lowest possible dose, for the shortest possible time, ideally less than 12 weeks."

At 3.3 Professor Banerjee noted that "Antipsychotic drugs show minimal efficacy for the treatment of BPSD"

(BPSD = behavioural and psychological symptoms in dementia.)

In his concluding remarks Professor Banerjee states

"The use of these drugs in those with dementia has substantial risk attached, including a conservative estimate of 1800 extra deaths and 820 extra serious adverse events such as stroke per year" His figures relate to England only. He makes no reference to other serious adverse effects of antipsychotics such as tardive dyskinesia, an embarrassing but common side effect which, according to the British National Formulary, is irreversible.

1.13 In view of the previous three sections the Scottish government should consider introducing regulations for care homes for the

elderly which set out clearly the circumstances which must be met before antipsychotics can be prescribed to a resident, the maximum period of administration of an antipsychotic to a resident and the maximum dose. The Scottish government should also consider prohibiting the covert administration of any antipsychotic to a care home resident. The inspectorate should be required to enforce such regulations and not turn a blind eye to the administration of antipsychotics to care home residents on the grounds that they are not prepared to challenge the "clinical judgment" of medical practitioners. The regulations would not prevent doctors prescribing excessive doses for indefinite periods. However, they would, or could, ensure that care home staff did not subject residents, particularly those with dementia, to unnecessary risks.

Q4 What further action can we take to reduce the stigma of mental illness and ill health and to reduce discrimination?

A4 Individuals are too easily stigmatised by being detained under the 2003 Mental Health Act. The Act permits an approved medical practitioner to grant a detention certificate if he "considers that it is likely"

that the necessary conditions are met. However, when an individual appeals against being detained in hospital the Tribunal is only required to determine whether those necessary conditions "continue to be met." The Act does not allow for the possibility that an approved medical practitioner might occasionally make a mistake. In my paper of October 2011 "It gave my justice", I have drawn attention to conclusive evidence that a mistake was made in one particular case but that the individual in question has been quite unable to remove the stigma placed on her as a consequence of having been detained. Further information about this case is contained within my papers of May 2011 and August 2011. These are entitled "Unsatisfactory Mental Health Legislation" and "Unsatisfactory Mental Health Legislation 2". Copies have been provided to the Scottish Government.

Basically I have argued that Scottish mental health legislation should be amended to take account of a 2004 judgment of the European Court of Human Rights and also a 2004 Recommendation from the Council of Europe. I have also suggested that a high proportion of those detained under the 2003 Act have been unlawfully detained.

As for the reduction of discrimination,

it is obviously helpful if well known personalities can make it known that they have been detained on grounds of unsoundness of mind but that they (apparently) are not raving lunatics who present a danger to the public. It might also help if data could be provided concerning the proportion of people with mental health problems who actually pose a significant threat to others. It is likely to be fairly low though there may be a belief that the mentally ill are dangerous.

It is possible that those with continuing mental health problems tend to perform less well in employment than the average employee. If this is the case, then it might be unfair to be critical of employers who prefer not to take on an individual who cannot be relied on to cope with, for example, the pressures of being a school teacher. The employment of such a person would be unfair to the pupils.

Q9 What further action do we need to take to enable people to take actions themselves to maintain and improve their mental health?

9.1 Since antiquity the ideal has been a healthy mind in a healthy body, the implication being that people should take care of their physical health. It may be that people who do attempt to look after their physical health are at less risk of developing mental health problems. Unfortunately looking after one's physical health does not eliminate the risk of developing dementia, though it may reduce the risk. Evidence about such matters might be worth gathering: evidence as opposed to opinions.

9.2 One way to maintain good physical health is to exercise regularly. There is good evidence that exercise, including walking, can be an effective way of avoiding or coping with depression, provided that the exercise is regular. Once a person gets into the habit of exercising regularly it ceases to be a chore. In fact, a regular exerciser is liable to be unhappy if, for any reason, it becomes impossible for a time to exercise as normal. The pleasure of resuming exercise is all the greater in these circumstances.

9.3 People might be more prepared to take responsibility for their own mental well being instead of going to the doctor

for a prescription of something to make them less depressed, less anxious or better able to sleep at night if they were made fully aware of the risks of taking such drugs. Some people avoid taking medication unless absolutely necessary in order to avoid the risk of being adversely affected by the side-effects. It may be that such people have a greater awareness of their mental states and are better able to tolerate stressful situations or have a better insight in how to cope with them. Some individuals, such as Ranulph Fiennes, have developed high levels of determination which permit them to cope with physical challenges. It may be that it is possible to develop such levels of determination which permit individuals to cope with mental challenges. It is noteworthy, perhaps, that an elderly person who has lost a spouse often responds to those who ask how they are coping by saying that they are just having to get on with life - they have no choice. One wonders how individuals cope in war situations which can put civilians under seemingly intolerable stress. Yet somehow they just cope. Going to the doctor for a prescription would not do anything to remove the

genuine cause for their concerns.

9.4 Some of the stresses that cause mental health problems and can lead to suicide are financial worries. These financial worries can be caused by people being under the misapprehension that they need expensive material possessions or to go on holidays abroad in order to be happy. As someone who has been married for over fifty years I am well aware that it is possible to be perfectly content while living a simpler lifestyle than is considered the norm today. Also an aunt reflecting the 1920's told me that although her family may have been poor they were happy. Her mother, my paternal grandmother was officially a pauper for a time during the Great War after losing her husband (in a road accident) and being left with three young children with a fourth on the way. She was one of those who just had to cope and who did cope. It is alleged that around ten percent of adults in Scotland are taking or have taken antidepressants. It is likely that in a high proportion of those cases, they could cope perfectly well without those drugs. It may be that they have permitted to let their

finances get out of control as a result of having had too high expectations or unrealistic expectations as to what was necessary to achieve happiness. It is likely that they do not appreciate what many people had to cope with and did cope with in the past and that, as a consequence they lack a certain amount of mental toughness.

9.5 Notwithstanding the observations made above there can be no doubt that some people have mental health problems that they are incapable of resolving without help. However, some of those who have been subjected to involuntary treatment have greatly resented such treatment. The aim should be to provide treatment on a voluntary basis to people who have genuine mental health problems. This policy might make it more likely for individuals to seek the help that they need. The situation at the moment is that people can be detained in hospital and stigmatised simply because they are not compliant with the medication that has been prescribed by a psychiatrist. Some psychiatrists seem unwilling to acknowledge that, except in exceptional circumstances, adults have a right to refuse treatment. Treatments which are found particularly objectionable are depot injections and courses of electro-convulsive therapy.

Q 11 What changes are needed to the way in which we design services so that we can identify mental illness and disorder as early as possible and ensure quick access to treatment?

11.1 Doctors should take account of the possibility that an individual's unhappiness might be a consequence of that individual becoming less able to cope with the necessary tasks of everyday living as a consequence of mild dimentia. In particular, the individual might have difficulty coping with his or her finances. In such a situation, it is important that the doctor does not bring the consultation to a close after a few minutes with a prescription of an antidepressant but takes time to listen carefully to what the individual might have to say. The doctor, in such a situation, should also consider having the individual properly assessed and should also, if it seems necessary, try to arrange that some support mechanism is put in place.

11.2 It is not always obvious that someone is suicidal. One of my former colleagues committed suicide a few hours after trying to speak to me. I did not stop as I was going for lunch at the time.

I sometimes wonder whether it would have made any difference if I had stopped and listened to what that man wanted to say to me. Although doctors have limited time for patient consultations then should, in my opinion, make time to listen to patients who wish to speak about their problems. In another case known to me, a woman wished to speak to her doctor about a problem which the doctor could probably have helped to resolve. However, all the doctor did was prescribe an antidepressant. The woman in question did not commit suicide but was detained under the 2005 Act. In my opinion, the woman would not have been detained had the doctor been more prepared to listen sympathetically.

11.3.1 Doctors should not be encouraged to prescribe antidepressants to individuals who present themselves at their surgeries. There have been concerns expressed about the increase in antidepressant prescribing for some years now. An article in the BMJ on 5 February 2005 made reference to a review which concluded that firm evidence is lacking that mild to moderate depression is responsive to antidepressant medication. An article in the BMJ in

30 April 2005 noted that concerns have been raised about the medicalisation of human distress and the safety of antidepressants. It observed that "Despite concern about the dangers of antidepressants, evidence of ineffective and inefficient prescribing and the effectiveness of alternative treatments, drugs are overwhelmingly the mainstay of treatment for depression in general practice".

11.3.2 In an article in Scotland on Sunday on 24 May 2007 it was suggested that depression was "the new back pain". Research was reported that one in six people who were on sickness benefit had been awarded it because their doctor had issued them with a sick note stating that they were depressed. The article asserted that "We are medicalising unhappiness in a ten-minute consultation".

11.3.3. In order ~~to~~ prevent (avoidable) adverse reactions doctors are advised in the BNF that they should "never use any drug unless there is a good indication". The general advice states

> "Medicines should be prescribed only when they are necessary and in all cases the benefit of administering the medicine

should be considered in relation to the risks involved. This is particularly important during pregnancy, when the risk to both mother and foetus (sic) must be considered" Appendix 4 of the BNF provides guidance concerning the prescribing of antidepressants during pregnancy. Basically, the advice is to avoid unless there are compelling reasons.

11.3.4 The 2001 document "Standards for integrated care pathways for mental health" draws attention to the fact that rating scales exist to measure the severity of depression. Doctors should be encouraged to use one such rating scale in order to avoid prescribing antidepressants to someone who is suffering from only mild depression, something that would not be in accord with the guidance in the BNF The prescription of antidepressants should not, of course, be the first resort Obviously regular exercise can be recommended. It might also be appropriate to suggest that counselling might prove helpful. Emotional support and advice about practical difficulties is likely to be found helpful by some individuals.

11.3.5. A doctor friend of mine (now retired)

has alleged that doctors often bring a consultation to an end by handing their patients a prescription. In the past this would commonly be a prescription for an antibiotic, something that probably led to the overprescription of antibiotics and hence to the development of bacteria that are resistant to antibiotics. At present there is probably a vast overprescription of antidepressants, something that will impose an unnecessarily large financial burden on the NHS while, at the same time, causing large numbers to suffer unnecessarily from the side effects of these drugs.

11.4 Basically the answer to the question is that doctors should not be in a hurry to assume that the prescription of an antidepressant is the most appropriate thing to do when a patient is obviously unhappy nor should there be any assumption that "treatment" is necessary. If there is any possibility of dementia developing then the provision of advice and support should be considered together with a programme of regular assessment. This is particularly important in the case of an elderly person who lives alone and has no family.

Q 35 How do we ensure that staff are supported so that care and treatment is delivered in line with legislative requirements?

In section 14 reference is made to the Millan principles that underpin the 2003 Act. The 2008 Limited Review, chaired by Professor Jim McManus, did not, in spite of its remit, investigate the extent to which there was adherence to the Millan Principles in psychiatric hospitals. However, the research conducted by Dr Jules Ridley et al (A cohort Study) reported on page 5 that "There are clearly challenges to implementing the principles underpinning the Act in practice." This suggests that some staff are ignoring the principles, something I found in a detailed case study which I have conducted. Notwithstanding the duty of the Mental Welfare Commission to promote best practice (2003 Act, s 5(h)) it is clear that something more is needed. The Scottish Government should consider establishing a monitoring mechanism along the lines of what is contained in Chapter VII of the 2004 Recommendation from the Council of Europe. The Millan Report in chapter 37 recommended that there should be set up a Monitoring Group distinct from the Mental Welfare Commission.