Mental Healthcare Report: compulsion versus autonomy

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Mental health professionals welcome the main thrust of legislative reforms to provide the 'least restrictive' treatment. However, they note that detention is now the rule on some wards.

"On organic mental health wards, 95% of people are now detained – even those who may not be resisting treatment – and it's the same percentage for our learning disability wards. Case law is driving more people to receive treatment under the safeguards of the Mental Health Act," says **Dr Ahmad Khouja, Medical Director at Tees, Esk and Wear Valleys NHS Foundation Trust.**

"The direction of travel for more autonomy is important, but the difficulty for clinicians, and service users agree, is that there is not really much of a choice when a patient wants to do something one way, and clinicians say 'if you do that we will do a Mental Health Act assessment on you'."

START A CONVERSATION

Khouja says that in order to avoid this, these issues must be built into discussions at an early stage. "The more upstream you are about what the choices and consequences might be and come to a shared decision about what route you want to go down, the more likely the right choices and approaches will be made at the point of crisis. "Our Trust is radically redesigning services so when you talk about compulsion and autonomy, that kind of 'sharp' decision-making affects a very small number of the people that access our service. For 95% of people it's not an issue – we are working collaboratively."

If psychiatrists and the legal profession are talking about the question of capacity, and whether there should be a move to a more 'capacitous' based Mental Health Act, then Khouja agrees: "We can't ask for parity of esteem yet have an intervention that is based on the fact that we can do it even if you have capacity. I have always been in favour of a capacity-based process. Even though it might not make life easier, for clinicians, it's about doing the right thing."

SENI'S LAW

Seni's Law – the Mental Health Units (Use of Force) Act – that received Royal Assent last year – commemorates Olaseni Lewis, who died in September 2010 after being restrained by police officers at an NHS psychiatric hospital.

Dr Keith Reid, Associate Medical Director for Positive and Safe Care at Northumberland, Tyne and Wear NHS Foundation Trust, is also part of a national team across providers that has drawn up 'Towards Safer Services'; new national guidance on reducing restraint and use of force on wards, which goes to the heart of Seni's Law.

The national guidelines will be published by BILD (British Institute of Learning Disabilities) for the Department of Health, but Reid says that in the three years since a strategy compliant with the guidelines was implemented at his Trust, they have achieved "a cultural change at all levels of the organisation that has reduced our restrictive interventions, while reducing assaults on staff".

Key to its success was that senior managers devolved decision-making to staff and patients. "If staff don't think they can make autonomous decisions at the right level, they are less likely to let patients make them."

Reid says the guidelines work on three levels:

- Primary interventions include consistently providing a supportive patient-centred ward environment, such as regular mutual support meetings for patients, a clear complaints system and good regular supervision.
- Secondary interventions support those at risk, are individual and planned in advance. Do we have a clear care plan? What supportive medications would the patient accept? Do people have one-to-one time with their nurse talking them down, or do they find it stressful and punitive? Do they prefer to be by themselves – taking out their frustrations in a contained way – perhaps in the gymnasium, for example?
- Tertiary interventions include seclusion, increased observations and compelled medications. "They must be efficacious and the least restrictive option. We want to move with patients to where it is a collaborative process – where patients themselves anticipate how they would like the service to happen for them. Tertiary interventions are discussed in

advance; for example, do they prefer oral medication to the option of injection or being held in restraint?"

But Reid stresses that all the above are only done if it is safe. "We have to keep this real, or patients and staff would not buy into it. If someone is about to commit a violent offence, then that must be stopped. Prevention of conflict at all is the aim."

INDEPENDENT MENTAL HEALTH ADVOCATES

All 'qualifying patients' treated under the Mental Health Act have the right to access an IMHA, with increased rights of access proposed in the review. While it is a laudable aim, **Mel Wilkinson, Head of Mental Health Legislation at Tees, Esk and Wear Valleys NHS Foundation Trust,** says it will require either additional resources to be provided to local authorities, or other organisations enabled to commission and provide services, so long as there is no conflict.

"If not, there will be people who are entitled to something in statute, but they will be unable to access it, or we will see prioritisation, with detained patients taking priority, which is effectively what the IMHA service currently is commissioned for."

Additionally, Wilkinson feels that as the IMHA service was specifically set up to provide advocacy for patients subject to the Mental Health Act, "to open this up to all, as proposed, may dilute its purpose and effectiveness".

She feels the use of video conferencing for mental health assessments may speed up the assessment process, but it may not alleviate the age-old problem of finding a second doctor. "The lack of face-to-face assessment in person may also impact the quality of the assessment carried out. The recommendations, as set out, do not appear to recommend this, and new technology is proposed with regards to patients' access to records and information as well as timely access for clinicians to information to assist with their assessment."

Wilkinson feels that patients with both significant mental health and physical health needs are often cared for in 'silos' with insufficient dialogue between services, which can be particularly prevalent within a community setting. "Within an inpatient mental health setting, services are aware that the physical health needs of detained patients are a high priority, but it can sometimes be challenging to ensure that equitable care is provided to this group in terms of their physical healthcare needs."

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