HUG
ACTION FOR MENTAL HEALTH

MENTAL HEALTH OFFICERS:

OUR EXPERIENCES OF THEM

The views of 88 people who have experienced mental health problems on the role of Mental Health Officers

AUGUST 2010

Highland Community Care Forum
connecting users connecting carers

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WHAT IS HUG?

HUG (Action for Mental Health) is a network of people who have experience of mental health problems.

At present July 2010, HUG has approximately 400 members and 14 branches across the Highlands. HUG has been in existence now for 14 years. Between them, members of HUG have experience of nearly all the mental health services in the Highlands.

HUG wants people with mental health problems to live without discrimination and to be equal partners in their communities. They should be respected for their diversity and who they are.

We should:

- Be proud of who we are.
- Be valued.
- Not be feared.
- Live lives free from harassment.
- Live the lives we choose.
- Be accepted by friends and loved ones.
- Not be ashamed of what we have experienced.

We hope to achieve this by:

- Speaking out about the services we need and the lives we want to lead.
- Challenging stigma and raising awareness and understanding of mental health issues.

HUG's aims are as follows:

- To be the voice of people in Highland who have experienced mental health problems.
- To promote the interests of people in Highland who use or have used mental health services.
- To eliminate stigma and discrimination against people with mental health problems.
- To promote equality of opportunity for people with mental health problems irrespective of creed, sexuality, gender, race or disability.
- To improve understanding about the lives of people with mental health problems.
- To participate in the planning, development and management of services for users at a local, Highland and national level.
- To identify gaps in services and to campaign to have them filled.
- To find ways of improving the lives, services and treatments of people with mental health problems.

- To share information and news on mental health issues among mental health service user groups and interested parties.
- To increase knowledge about resources, treatments and rights for users.
- To promote cooperation between agencies concerned with mental health.

INTRODUCTION

In the summer of 2009 HUG was asked if it could canvas its members' opinions on Mental Health Officers (MHO's); both our views about them and our direct experience of the work that they do.

In the last few years HUG has carried out a lot of work on the Mental Health Act with its members. Many of our members have experienced hospital admission, so it could be assumed that we were likely to have as much (if not more) experience in this subject than many other groups of people with experience of mental ill health.

We were provided with a set of questions by the Lead Officer for Mental Health and Learning Disabilities at Highland Council and asked these questions at the regular rounds of meetings that we hold with our members across Highland.

In total we involved 88 people in these meetings, the vast majority of them users of mental health services. The meetings were held throughout Highland region but also included one meeting in Oban where we work with 'Acumen' to include the views of members in Argyll (covered by NHS Highland but not Highland Council).

We took notes from each meeting and then compiled them into the following report which was approved by the HUG Round Table (a group of HUG representatives who approve our reports) and commented on by outside stakeholders.

In the meetings themselves we found that many people were unaware of the function of Mental Health Officers and that it was therefore difficult to get as comprehensive a view of this topic as we do when discussing other subjects. However, this finding in itself is of value and some of the questions we asked did not require direct experience in order to be answered.

Nevertheless we did gain views gained from direct experience in most meetings and these inform this report.

WHAT IS A MENTAL HEALTH OFFICER?

As so many of our members did not know much about Mental Health Officers, we asked Highland Council to provide us with a description of what an MHO is and does. This follows:

A Mental Health Officer (MHO) is a social worker with at least two years post-qualifying experience and who has successfully completed the nine month

postgraduate Mental Health Officer training course which in Highland is provided by Robert Gordon University.

MHO's are approved to act in their own Council area. They are required to undertake a minimum number of statutory tasks each year to continue to be accredited, including training. Each MHO has a mentor who ensures that they are meeting their requirements. MHO's are required to have a thorough knowledge of mental health legislation, a good understanding of mental disorder and its impact on individuals and families, and an ability to use their own judgement independently.

An MHO has a number of significant responsibilities under both the Mental Health and Adults with Incapacity Acts. Under the Mental Health Act an Emergency Detention cannot go ahead without the consent of an MHO (unless it has not proved practicable to get hold of one), a Short Term Detention Certificate requires MHO consent, and only an MHO can make an application for a Compulsory Treatment Order. MHO's must always be consulted when decisions are made about renewing or varying Compulsory Treatment Orders. They will attend Tribunal hearings and give evidence.

MHO's are also required to submit reports to accompany Welfare Guardianship applications. MHO's are also responsible for advising patients and families of their rights and providing information about the process of detention.

Unlike other social work tasks, an MHO cannot be instructed as to the decision they make regarding consent to detention. MHO's have to act independently and use their own judgement. The reason that social workers act as MHO's is because they are employed by a different organisation than doctors and the doctor cannot tell the MHO what decision to make.

MHO's often have to make difficult decisions which balance the need to use the law appropriately to ensure that patients are given the care and treatment required when they are unwell, with respect for the person’s individual rights and dignity.

(Supplied by Highland Council Social Work Dept).

DO WE KNOW WHAT A MENTAL HEALTH OFFICER DOES?

In the regular HUG meetings that we hold, we have consulted our members on aspects of the 2003 Mental Health (Care and Treatment) (Scotland) Act on about four occasions in the last few years. At each scheduled branch meeting we give feedback on our work which often involves the Mental Health Act.

In addition, many of the meetings we hold are held at drop-in centres which often have some information available on the Mental Health Act.

It is therefore quite surprising to find out how little knowledge many of us had are about the role of an MHO.

In total 64% of us had not heard of a Mental Health Officer at all. Of the 36% of us who had, many of us did not know what a Mental Health Officer was meant to do.

We had 17 members present at the meetings who revealed direct experience of being detained under the Mental Health Act, and of these 58% had not heard of a Mental Health Officer either and did not know what they were meant to do. Sometimes this was because the officer did not explain who they were or what they were meant to do. Sometimes it was because we were too ill to take in the information that the MHO gave us:

"I have one but no idea what she should do."

These findings are quite a surprise to us and quite alarming, considering what the MHO's role is and how informed we had thought our membership was.

We also asked people about the Mental Health Act and again found widespread lack of knowledge and understanding.

38% of us were unaware that there was a new Mental Health Act (i.e. the 2003 Act) and/or of its impact in the last few years.

Considering that the Act has an impact on all our members, but also that there has been a lot of publicity about the act over the years, this is a worrying piece of information. It must make us wonder about how information could be better provided to us on policies and legislations that have a direct effect on us.

Most of us would like to know about the role of a Mental Health Officer but there were a few of us who said that we would not like to know once we realised that they had a role in the detention of people with a mental illness. We found the subject distasteful and didn't want to hear more about it.

DO WE NEED THE INDEPENDENT VIEW THAT A MENTAL HEALTH OFFICER OFFERS?

Most of us agreed that this view was very important and acted as an important safeguard to the detention of people with a mental illness. Some of us said that even where it was obvious that we needed to be detained, the position of

an MHO was an important one to have, even if only as a theory or principle that will ensure the perception of a view separate to that of a psychiatrist and the person who is ill.

However, some of us disagreed. There were two main reasons for this:

- We should trust the system to provide us with the care we need. If we are ill enough to be sectioned it will inevitably mean that we are in a position where we need help. We should accept this help without it needing to be questioned. To challenge this may damage the support we get afterwards, create divisions in our care team and cause us unnecessary distress. We should have more faith in our doctors than requiring independent views of their decisions.

- There was a strong feeling that MHO's tended to side with the psychiatrists and others. So we feel that there is not much point to having another voice which usually is of the same view.

ARE MENTAL HEALTH OFFICERS INDEPENDENT ENOUGH TO DO THE WORK THEY DO?

Most of us thought that MHO's are not independent enough as they are generally part of 'the system', especially those who are part of mental health teams. The extent of their objectivity and openness was questioned because of this.

However, a few of us felt that they were able to separate this out and that sometimes MHO's were more likely to align themselves with our opinions about how we should be treated despite confronting opposing views:

"…be better if they were completely independent but they do tend to take our side."

If MHO's disagree with the need for a section then they are quite likely to be disagreeing with fellow colleagues who originally tried to put the process in motion. Many of us do not think MHO's will do this easily and so we are unlikely to have faith in their independence or believe that they are allowed to be fully independent:

"They are part of a multidisciplinary team; it depends who has the power and responsibility. It would be very hard to challenge the people you worked closely with."

"They had one-to-ones with the psychiatrist; they are more allied to them than to us."

Most of us said that in an ideal world an MHO would be independent of all services:

"They should have nothing to do with the Community Mental Health Team, NHS, the Police or Social Work."

By being attached to the Social Work Department, which already carries its own stigma, we may lose faith in them even more.

However, despite these views many of us felt that, in reality, the independence of an MHO was not so much of an issue. We had faith in them and doubted that they would 'rubber stamp' decisions. We felt that true independence rested on the people involved and varied from case to case.

Some of us felt that MHO's would be much better able to do their job if they worked in partnership with other professionals, even if this caused some potential conflict to their independence.

But we did feel that the perception we had was important. If they appear to be allied with other people then this could be damaging, despite their actual practice which may be very independent:

"…depends on the integrity and character of each individual."

We wondered how easy it was for MHO's to assess the need for detention and felt that they often only came into contact with us in a crisis. In order for them to carry out their job well we felt that they need a wide knowledge of us as people so that they can come to balanced decisions. This often means that they should have a prior knowledge of us. This is not something that we feel is routinely the case.

Some of us said that we can never feel equal to someone with the status and duties of a Mental Health Officer and because of this it would always be hard to trust in them.

Some of us have such faith in our helpers that the reason a Mental Health Officer exists is baffling to us:

"I don't understand; we trust our doctor anyway."

They fact that a Mental Health Officer and health staff may disagree is extremely confusing to some of us. We assume that if decisions are being made about our care then they should be shared by all our helpers:

"Sometimes the MHO and the NHS are fighting each other. If we want to be able to trust them, then it would be good if there were no disagreements."

Because we see the MHO's as part of a system that can lead to detention we may not consider contacting them even though we get on well with the person concerned:

"If I were in hospital and I were pushed I would phone the drop-in and not the MHO, as I don't trust the system and they are part of it."

DOES THE MENTAL HEALTH OFFICER GIVE US THE INFORMATION WE NEED?

We had mixed views on this. Some of us said that we received all the information that we needed and others felt that we received very little information or that it was given in the wrong manner:

" I received all [the information] that I wanted."

"[she was] very helpful."

Some of us felt that we were given little information to start with but that later on (perhaps when we were seen as more capable of absorbing it) we were given more information.

One of the problems we faced was that when we were distressed it can be hard to take information in, and the way in which it is offered is not always appropriate:

"They offer pamphlets, they don't go through them with you, you just throw them in the drawer."

"It can be hard to take it in because you are all dosed up."

Sometimes we feel that there is an assumption that we know more about the Act than we do know, especially if we have been sectioned before.

Some of us said that MHO's didn't introduce themselves properly; that they just introduced themselves as an MHO with no explanation or that they did not consider the best way to provide information:

"They should give you time and breathing space, they should treat you as a person not a label."

WERE THEY HELPFUL?

We had a mixed response to this question. Some of us, especially in retrospect, are very happy with the help we have received whilst some of us still feel angry.

Feeling in control is an important aspect of our contact with the MHO and can influence how we deal with them:

"I felt more in control with the older one."

Some of us have MHO's who seem to go beyond the call of duty, especially if we see them for other issues (as part of their wider role as social workers) as well as the issues to do with detention:

"She's supportive and encouraging and practical and accessible. I can see her easily and she will put time aside to see me out of hours."

"Very helpful, she gave me all the information she could … and helped all she could."

"She is wonderful, co-ordinating everything, leans over backwards to help but [she is] tied to the system but still does all the forms and is on my side and knows me well."

"They can be very helpful indeed and put themselves out for us."

Sometimes being challenged and in the presence of someone who takes a different view to us can be seen as helpful and at other times as the opposite:

"They showed me that my life was out of control so, yes."

"We did disagree on some things but that is normal."

"They didn't go into some of the issues but then I was very unwell to start with."

Sometimes our contact with an MHO is limited so they may not appear to be helpful:

"It would help if I saw her."

"They didn't help with my troubles and I only saw them a little."

Some of us feel completely alienated from them and have no belief that they offer help.

The situation we find ourselves in may make it inevitable that we don't feel we are helped but sometimes we just feel that they are in themselves unhelpful:

"The person being sectioned would not have felt she was being helpful."

"Absolutely not [helpful]."

"[I] had to wait seven hours for the ambulance."

DO THEY TREAT US WITH RESPECT?

Again we have mixed views on the respect we were offered. Some of us were very impressed with how we were approached and others were upset at the MHO's approach.

Sometimes we are in a state where it is hard to communicate and finding a person perceptive enough to understand 'where we are' signifies being treated with respect:

"I needed to be able to realise how bad I was. He sussed me out so he was a good man and must have been doing his job properly."

"My MHO is my social worker and is very supportive and therapeutic even when I have turned against her."

If we know our MHO already this can be helpful:

"My MHO was very good. I knew her first. She saw me in the police cells and got me out."

However, sometimes we are very worried about what is happening, especially when very distressed and encountering many strangers asking us questions:

"He asked 'what's your name' and I couldn't answer, I was very frightened of him."

"I never saw my MHO until I was in hospital and the section happened. No alternative was offered."

Sometimes the speed with which sections need to be carried out can leave us feeling ignored and diminished:

"They did a social circumstances report but they never spoke to my husband and hardly at all to me as they were in a huge hurry."

And when they don't turn up for appointments this can signify a lack of respect to us:

"…[the MHO was] absent from all my meetings."

"[they] had to cancel a Tribunal as they didn't arrive."

Sometimes it feels as though they don't listen to us as much as we would like:

"They don't take our views into account."

Because being sectioned happens at a traumatic time and is in itself traumatic it can be hard to recollect our feelings:

"Not well enough to remember. I have been sectioned a lot but I don't remember."

WERE OUR CONCERNS LISTENED TO?

In a situation where actions are being carried out against our will it can be hard to feel that our views are being listened to:

"I was detained for eleven months. There was no getting out of it."

"They just do what they have to do to assess you."

"[I was] totally unimpressed, they didn't listen; they didn't use the mental health act principles."

"I haven't spoken to her much."

"I don't feel comfortable with her."

However, some of us still feel that we were involved in what happened:

"She paid attention to my advance statement that I had no recollection of writing."

"It seems to be their duty to find out about our background; they listen to us and talk to us."

"The first time I was sectioned the MHO never left me for 7 hours, it was very good."

"They do, do a lot of talking."

DO THEY CONTINUE TO VISIT AFTER DETENTION?

Most of us said that we just saw our MHO for the process of detention and very little, if at all, afterwards.

Those of us that saw the MHO afterwards were often complimentary about our MHO:

"I see her every week, she is excellent."

" very very good."

ARE THEY PROFESSIONAL?

Some of us felt that our MHO was very professional and others were disappointed at how we were treated and regarded this as unprofessional:

"She puts me at the top of her agenda."

"Very good, very professional."

"Generally the majority are very open and do the job to the best of their ability."

"They have to be; they have a big responsibility and are aware of it."

It was hard for some of us to consider the work of an MHO as professional because of the consequences of their actions on us and the feelings that this could provoke in us:

"Yes [professional] but they can take away your liberty so it doesn't feel nice at all."

"They can have you dragged out of the house, with no respect."

"If they want, they can get you dragged 'up the road' by the police, and think they are doing you a favour."

"Very amateurish."

"They might have said they were an MHO but I have very little recollection of this. I don't know their name or what they said to me or what they did."

IS THE MENTAL HEALTH ACT AN IMPROVEMENT?

Only 62% of us were aware that there was a new Mental Health Act since 2003 and many of us who knew that there was a new Act had no idea whether it was an improvement on the old Act or not. This was because of a lack of knowledge of the content of the Act, lack of knowledge about the changes that had occurred since it was implemented or because we felt too little time had passed for us to have an opinion.

However what some of us did believe was that:

- The Act is different to the law in England and Wales and there was some feeling that life may have improved under the new Act.
- We believe that we have more of a say in our treatment, that we have better rights and that we are listened to more.
- We believe that people try not to have to section us and, if we have an advance statement, listen to this.
- We felt that there is now better contact between services.
- We felt that treatment has changed because of the principles that underlie the legislation but also had a feeling that these changes would have come into being anyway.
- We have noticed that it is easier to access advocacy.
- We felt that community based treatment orders were a better option than being detained for long periods in hospital.

On the negative side:

- We felt that it was easy to overrule us and that people in charge of our care could do almost anything that they wanted to us once we were sectioned.

- We also felt that in the absence of any substantial new investment in mental health services there are still not enough services available to help us.

CONCLUSION

When drawing conclusions from this report it should be remembered that only a small number of people involved had direct experience of MHO's. It can also be noted that our views have been very varied.

Contact with an MHO has been mostly to assess us when it has been felt that an intervention, that we are opposed to, is required. So it is, perhaps, a little surprising how many positive comments were made by us. This may be a form of recognition by some of us who have actually been sectioned, that whilst the process of sectioning is unpleasant, it is necessary in some of our lives; and that sectioning is generally done in as sensitive a manner as possible.

On the other hand some of us who have been sectioned are still extremely angry about the fact that this has happened to us. This has resulted in us having lost faith in the system and also in the people who have been put in place to help us. It could be tempting to assume that this anger is a part of our illness but it is equally possible to understand it as the anger of any person who feels detention was unnecessary but who has nonetheless been detained. It would be good to see continued work to make this event as pain free and care-full as possible.

Some of us also felt that there were no alternatives offered in place of a section. It may be interesting to see how frequently people are offered therapeutic alternatives that do not involve compulsion and whether these could be offered more widely.

The lack of knowledge that so many of us have about the Act and about MHO's needs to be rectified. The spoken word doesn't work in some situations and posters and leaflets are often ignored or left unread. It would be good to find creative ways to make a subject, that may seem distasteful to some, an interesting and positive area to gain some basic awareness of.

It does seem that if we have prior knowledge of our MHO then they will seem less alien and threatening than if we tend to only encounter them when we are

about to be sectioned. This is not possible for a first section but presumably if we are a client of a mental health team should be possible.

We had a strong perception that, as MHO's are social workers and usually part of the system that deals with us, it is hard for us to perceive of them offering an objective opinion that may be opposed to that of their close colleagues. Many of us felt that we would have a more positive view of their work and more faith in their judgement if they were independent of all services.

In contrast some of us took a more pragmatic approach and felt that better decisions could be reached and more sensitive decisions made if our MHO's worked closely with the rest of the care team. These contrasting views may be worthy of more debate.

When we look at our knowledge of the Mental Health Act so far, it is good that the comments we gained were mainly positive. It is equally depressing that what is meant to be an exemplary piece of legislation has had so little impact on the people directly affected by it. In HUG we have a number of members with a detailed knowledge of the Act but the majority remain unclear about it. It would be good if those who may wish to, can gain more understanding of it.

APPENDIX

EXPERIENCES OF MENTAL HEALTH OFFICERS

PERSONAL EXPERIENCE A

'I saw an MHO when I was being assessed for a 28 day section. I was upset and frightened but she seemed harassed and tired. I think she felt annoyed that she had to section me and that I was causing her a lot of bother for no particular reason at the end of a busy day.

She gave me very little information and as far as I remember just seemed to confirm that my emergency detention certificate was now a short term detention certificate.

I didn't see her again and was released once the section was lifted.'

PERSONAL EXPERIENCE B

'I don't remember much about my section. I think it was late at night and this MHO came to see me about an emergency detention as I wanted to leave hospital.

She was warm and cuddly and calm and tried to explain what was happening. She gave me various pamphlets that I only read briefly, much later on.

She told me that I would be put on a short term detention certificate later the next day. I can't remember much about that either.

She came in and went through everything again with me, and again I found it hard to listen. I just really knew that I was being sectioned.

She gave me even more pamphlets and told me all about my rights and strongly advised me to contact a solicitor and told me how to do that.

She then went away and I never saw her again. She was really nice to me but she still sectioned me.'

PERSONAL EXPERIENCE C

'I live in very rural Highland approx 100miles from the psychiatric hospital. I was admitted to hospital as a voluntary patient. Within 5 days I was put onto short term detention by my psychiatrist who I later learned had been in conversation with my husband. The hospital MHO did attend (but I never saw her again).

I didn't have an advance statement nor had I nominated a named person prior to admission. I engaged a solicitor after being sectioned – both he and I

thought I had correctly nominated a friend as a named person during the voluntary part of my admission. As a consequence my friend received the paper work for the first tribunal.

I didn't realise at the time how psychotic I was. I have a diagnosis of bipolar-disorder. Previous hospital admissions had always been for depression. On this occasion I was hypo-manic.

I have worked as a mental health advocate for a short time and am also quite well known round the hospital as an active HUG member. I think I gave the impression I knew the processes but it is quite different when you are very unwell- easily confused, extremely angry and feeling heavily sedated by medication. I think the hospital could have done more to ensure I knew what would happen – certainly the original MHO was not helpful and didn't even get back to me.

I did get in touch with Advocacy Highland very quickly – they were extremely helpful.

Eventually my husband became my named person by default. This made me even more angry, as he was agreeing with my consultant. It is still an issue of contention and I've now put in my advance statement that I do not wish him to be my named person; in fact I don't want one at all. Like many other people, the nomination of a named person is extremely difficult.

I do now have an advance statement, which I have written with the help of a Community Psychiatric Nurse. We intend to review it annually. My consultant had suggested I write one, but it never occurred to me I would be sectioned hence it didn't get to be a high priority.

I contested the Short Term Detention Certificate (S.T.D.C.) and lost. I went on to have a further two tribunals to argue against the Compulsory Treatment Order (hospital based) which I was put on. An MHO from my local Community Mental Health Team wrote the social circumstances report, but with no consultation with my husband. Some personal issues which may have contributed significantly to my illness at the time were not mentioned.

There was a definite assumption that just because we have been married a very long time there are not any relevant problems. My psychiatrist was aware, but I wouldn't have told the MHO (I didn't get on with her particularly well). She was always in a great hurry, works part time and has a 2 hour drive to get to the hospital to see me. She did attend the pre-Compulsory Treatment Order (CTO) meeting, but was unable to be at my second tribunal – in fact the hospital social worker could not find any MHO and a Highland Council solicitor attended instead!

The nursing staff did not give me any real support re. the tribunals, and I was certainly devastated by "losing" - especially the final one, which was marginal. My advocate tried to offer support, but I don't remember the MHO attempting to spend any time with me – although I know I was very angry. My consultant did lift the CTO on the day I was discharged after a week's pass at home.

I put a huge amount of energy/hope into the tribunals. The detention was appalling to me – I felt like a prisoner. My husband didn't visit often (I didn't know until afterwards that he had been advised/told not to). Several HUG friends were great though in spending a lot of time coming a long way to visit, and I really appreciated that. The ward environment was so boring, especially at week-ends, and I was confined to the ward for some weeks, unless there was a staff escort (not often at week-ends). There is no shop, so some days it was not possible to get a newspaper. Also there was an issue with my laptop and internet access, which is very limited for patients.

I was made a "specified person" and had my mobile phone taken from me.....then I was limited to a very small number of phone calls a day from a very public phone. I felt so isolated and even more angry. It was very difficult to find out the procedure to contest the removal of my phone, and even when I did it was difficult to get my request to my Consultant/Responsible Medical Officer. At that point it was still thought a friend was my named person and I was able to phone her daily.

I appreciate that the role of an MHO can be difficult and demanding. Good interpersonal skills are vital so that any future work with the individual is not jeopardised by the statutory duties of the work. Through HUG I have been involved on several occasions with the training of future MHO's. I feel it is so important that they have some understanding of what it is like to have a mental illness. Now I am in a better position to try to explain the feeling of having one's liberty curtailed – even if with hindsight it was justified.'

Experience D

'I saw an MHO for my compulsory treatment order application. He was very quiet and gentle and soft spoken. He seemed to really want me to understand why I was being sectioned and to agree with it.

I would have liked to please him but I didn't agree with him and he just agreed with all the other people who didn't agree with me.

He had to travel over 60 miles from where he was based to see me and was quite hard to contact.

He was quite pleasant when he did the social circumstances report and was keen to listen to me and try to adjust to what I wanted, but all I wanted was to not be sectioned and he had no intention of agreeing to that.

I can't remember much about him except that he seemed gentle and that we had some problems as the tribunal approached and we found out he was on holiday.'

Experience E

'I saw my Mental Health Officer for my short term detention certificate and my Compulsory Treatment Order.

She was nice, she didn't say much but she checked that I knew what was happening and why. For the S.T.D.C. she didn't do much accept agree with everyone else and tell me my rights and what was happening. She assumed I knew a lot about the Act, which was probably true but not as true as she thought.

For the Compulsory Treatment Order (CTO) she made sure that she consulted all the people that I thought were important, such as my named person and next of kin. She explained why she wasn't using my advance statement but that she was trying to act as close to its wishes as she could.

She advised me to have a solicitor but was fine when I said I didn't want either a solicitor or an advocate.

At the pre CTO meeting she was really nice and very apologetic when she agreed with everyone else. She seemed to really want to know what I thought and what the people close to me thought before she agreed to go ahead with the application.

She was very aware that I might be tired and not up to speaking to her and made room for friends if they were visiting when she was visiting too. She also made sure that I didn't have to go through my story all the time and took a lot of my history from my files. That was good.

She looked into all my criticisms of the CTO application in detail and tried to go through all my past records to check who was right.

At the tribunal she was fun to be with in a solemn way, we were able to smile and have a few jokes despite what they were doing to me. She said all the things I didn't want her to say but was very good at explaining to us the difference between a varied community treatment order and a suspended one and other technicalities that we got confused about.

I liked it that when I phoned her with questions. She always knew who I was straight away and could answer most things at once and if she couldn't she followed them up and got back to me.

If I had to be detained she was quite a good person to be detained by. It felt like she didn't take everyone's view at face value but considered my views as important too, even though she quickly decided that I was ill and talking nonsense, she tried to look at all the aspects of the restrictions they were placing on me. However, in the end everything the psychiatrist wanted to happen did happen and she agreed with it.

A little bit of me agrees with what she did now. If she hadn't done what she did I wouldn't be alive now.'

Experience F

'I have been in contact with mental health services for almost twenty years. When I was 27 I spent 4 weeks in Dunain House due to alcohol misuse problems. These problems did not go away; in fact they got progressively worse until 1995 when I was diagnosed with Bipolar Affective Disorder.

I managed my condition quite well for five years using Lithium to stabilize my moods. In 2000 a series of close family bereavements, plus a stressful job, saw my condition deteriorate to Bipolar 1 with a tendency for mixed mood rapid cycling episodes.

In 2001 I took the first of 3 serious overdoses which led me to be sectioned under the Mental Health Act.

Nothing in life prepares you for the total loss of freedom and rights which comes with a section. I managed two 72 hour sections in two weeks and came very close to being sectioned for 28 days. I literally had to beg to be allowed to stay voluntarily and be confined to the ward for a week.

My Social Worker, who was also an MHO, visited me in hospital and very carefully explained to me that I needed to be in the safe environment of hospital. Not a lot of what she said was making much sense at the time as I was by then very manic, paranoid and trusting no-one. She explained that if I didn't stay voluntarily in hospital then she would recommend at 28 day section for my own safety. I felt betrayed by her and our therapeutic relationship almost broke down completely. When I think back now I realise that all that was for my own good, if I had gone home I would almost certainly have taken my own life.

A few years later I started to become unwell again and was visited by my CPN. Without any warning he came accompanied by a MHO. Now anyone who has had a manic episode will know that mania has the wonderful effect of heightening your senses and perceptions of life. The whole afternoon was wasted as I went on my guard and did my usual trick of presenting well. The

MHO decided that I was absolutely no danger to myself and I went even more manic because I had won a victory over the system. Much drink and many tablets later my mood burned itself out but not without me hurting my family and putting myself in a lot of danger.

I know that it is not always possible but I for one respond better if I feel that I am at least in the loop of decisions. I prefer to know who is coming into my house and don’t like to feel tricked or cornered. I know tough decisions sometimes have to be made and I am grateful for services for keeping me safe for all these years.'

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