Experiences and Views of Compulsory Treatment in Scotland

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Study Background

- Millan Committee
- Mental Health (Care & Treatment) (Scotland) Act, 2003 (MHCT Act)
- 10 Key principles
- National research programme
- Commissioned by Scottish Executive/ Government
- Collaborative approach

Key Aspects of MHCT Act 2003

- New Mental Health Tribunals
- ‘Named person’
- Advance Statements
- Community-based compulsory measure
- Emphasis on social well being & development
- New professional roles

Study Aims & Objectives

Main aim -To evaluate stakeholder experiences & views. Key objectives: -

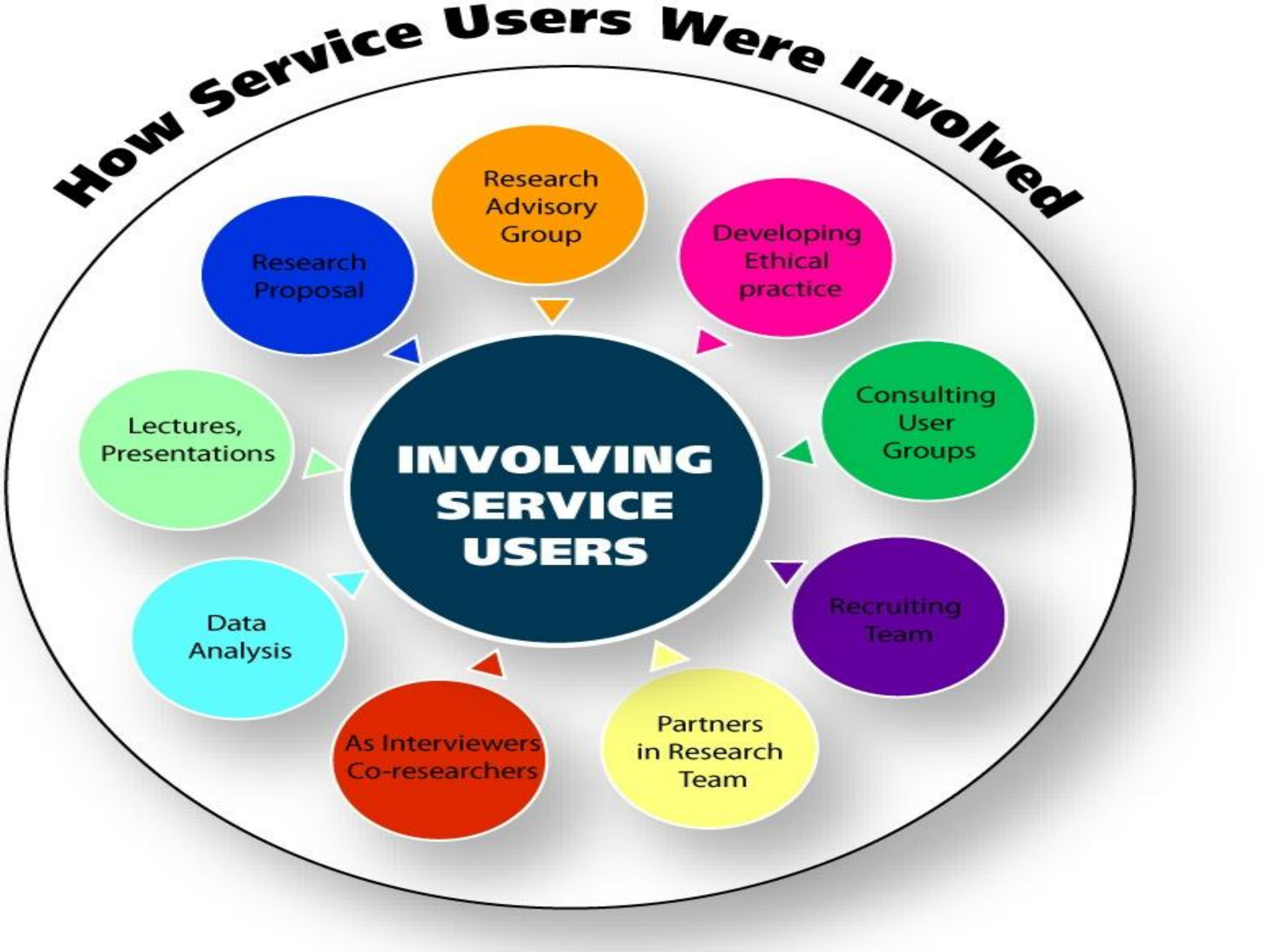
1. To identify and describe operation and impact of MHCT Act
2. To examine service user journeys over 1 year
3. To examine interaction with other legislation
4. To assess success of well being measures
5. To evaluate against Millan principles
6. To make recommendations

Research Methods

- 2 year project – 2007 to 2009
- Service users, carers, professionals
- Qualitative design:
  - Literature review
  - Telephone interviews
  - Face to face stakeholder interviews
  - In-depth interviews with SU at 2 stages
  - Focus groups/interviews with carers at 2 stages
- Co-researchers

Some of the Research Team

Involvement of Service Users



What Some Interviewees Said…..

- *It felt better that there was somebody there that understood”*
- *“If I was sitting with two officials I couldn’t be as relaxed, having a laugh as well as talking about these things”*
- *“Good that its also someone that’s been in a similar situation”*

Ethical Issues

- NHS Ethics – 6 months - evaluation
- Ethical approval from Faculty of Health Ethics Committee & State Hospital
- Ethical guidelines/protocol
- Emerging issues – service gaps, doing justice to individual accounts
- Need for flexible approach

Research Samples

	Stage 1	Stage 2
Service users (49)	49 people interviewed from 4 Health Board areas in Scotland	39 of the 49 people interviewed at Stage 1 agreed to be interviewed again
Carers (33)	21 carers mostly in focus groups (5 interviewed)	20 carers, mostly in focus groups (5 interviewed)
Health & Social Work Professionals, Lawyers and Advocacy Workers (48)	15 telephone interviews with contacts in national organisations 23 practitioners and advocacy workers interviewed in 4 HB areas	

Service User Sample

- Two thirds were men
- Mean age 40.5 years
- Youngest was 21 years
- Oldest was 63 years
- 8% BME background
- 8% people with learning difficulties and/or autism
- 35% community-based CTO

Most Recent Compulsory Experience

Category	Number	Percent
Short Term Order	7	14
Interim Order	2	4
CTO in hospital	13	27
CTO in community	17	35
Specialist Order – Criminal Justice	5	10
Unclear at Stage 1	5	10
Total	49	100

Discussion of Findings

- Journeys into compulsion
- Participation
- Treatment
- Community-based compulsory care
- Feelings about compulsion
- Impact of new professional roles & responsibilities
- A principled approach?

Stage	**E**	**A**	**B**	**C**	**D**	**E**
Part of the Compulsion Process	Non-Compulsion/ Stability	Episode Leading to Compulsion	Tribunal Process	Care and Treatment	Discharge from Care and Treatment	Non-Compulsion/ Stability

Pathways through Compulsion

Scottish Executive, 2005, *Mental Health Law Research: Update and Agenda 2005-2007*. Edinburgh: Scottish Executive.

Journeys Into Compulsory Care

- Complex, non-linear
- Diverse group
- Pre-compulsion
    - Start or escalation of serious MH issues
    - Stressful or traumatic events
    - Impact of social or environmental factors
    - Non compliance
    - Criminal justice system
    - Risk to self or others

Participation

Tribunals –

- *“I felt more involved. They asked me a question. I got a chance to talk you know and to ask questions, they asked how I was and what I thought. Before it was my doctor and the others talking you know, they didn’t give me any chance to talk.”*

- ***“I did get my tuppence worth, but it wasnae really worth anything”.***

Other Views About Tribunals

- Carers said was more inclusive but

"It's the lawyer, psychiatrist, then the lay member who in turn will address the psychiatrist, Mental Health Officer, the support workers, and anybody else who happens to be there. Then they might get to the Named Person."

- Professionals identified issues with short notice, differences in approach and impact on wider MH system:

"There's growing unease around the impact the pressures on professionals' time is having on those receiving services on a voluntary basis....appointments cancelled at short notice when psychiatrists called to Tribunals."

Participation - Advance Statements

- *“What I’ve said…is that every effort should be made that I stay at home before being rushed into the [hospital], and every effort be made by non-drug methods, drugs being a last resort, and that I should have some say in what drugs I’m put on.”*
- ***“Regarding medication, they’re going to give you what they want to give you....What is the point, it’s wasting everyone’s time.”***

Participation - Named Person

- *“I put her as my named person instead of my mum. Her dad was manic-depressive so she can relate to me whereas my mum can’t. Plus there are things that I wouldn’t want my mum to know. If she’d seen half the things that have happened or I’d done she’d probably have a heart attack.”*
- ***“I just felt he (relative) was not speaking in my interests and perhaps I was mistaken. I think I named a good friend of ours after that.”***

Carers’ Views of Named Person Role

- Afforded new rights to carers:
- *“Until we had the compulsory order (and being Named Person) you really were largely on your own and the information didn’t come to you, you had to seek it out and it was hard to come by…Since we had the compulsory order, we have found a lot more about what is available, what we’re entitled to and have had a lot more help.”*
- Professionals confused by the role:
- *“It’s made the professionals feel they don’t really know what to do with us as Named Persons … now they’ve got to find a place for us, but they’re still not sure about what that is”*
- Inherent tension bringing carers in conflict with their relative

Participation - Access to Advocacy

- *“The advocate used to visit about once or twice a week. He'd be in and out helping me and he's researching the paperwork at the moment for this section order…It's pretty good that he's going on a fact finding mission for me.”*

- ***“I spoke to somebody from P in the past, and I didn’t have any result with them. I didn’t feel that they were going to make a difference.”***

Care and Treatment

- *“I've asked what the side effects are and nobody will tell me…The pills are upsetting the whole system, making you really ill but no, its ‘take these pills because you've got this mental illness and everybody who's got this mental illness has to have this pill'.”*
- ***“The psychiatrist listened to what I had to say, not straight away but after I complained about it a few times then she decided to change my medication, see if it would make me feel any better and it did.”***
- *“I know I’ve got a care plan but I don’t know what’s in it. I see my RMO writing in it all the time but nobody has actually sat down with me like my key worker and told me what’s in it.”*

Care and Treatment – Activities

- *“It's also very, very monotonous, there's nothing much to do here and it's nothing that I can really focus on doing. Like I'm an artist and if I had a drawing board or some proper materials to work with, and I could continue doing art and sketch people's portraits but at the moment I'm using printer paper and I only have biro pens to draw with.”*

Community Compulsory Treatment

- Reality is complex
- View challenged that it is preferable
- Medication orders

Service Users' Experience

"It keeps me within the system and maybe being compelled to stay with it has benefited me..."

"It's been a good safety net if I have to go back into hospital."

"I want my own private life back. I don't want people coming to my house like a bunch of Mormons and saying 'oh you've got to do this today, you've got to do that today..."

Service Users’ View of Compulsion

- In retrospect, 52% felt it had been the ‘right thing’, “a necessary evil”
- 42% felt it unnecessary
- Complex – both resented as infringing human rights, and felt beneficial
- Hospital based detention disliked most

Impact of New Professional Roles & Responsibilities

- Pre concerns not borne out in practice
- Significant change
  - Psychiatrists
  - Social Workers
- Shortfalls in psychology services
- Two-tier mental health system
- Professionalisation of advocacy

Principled Approach?

- Challenges re reciprocity and ‘least restrictive alternative’
  - Gaps in resources
  - Limited use of community-based CTO
- Partnership with carers?
  - Mixed experience
  - Named Person role afforded rights
  - Feeling excluded and isolated
  - Still not always involved in plans for leaving hospital
- Aspiring to participation easier than achieving in this context

Some Conclusions

- Some improvements evident
- Listened to but not heard?
- Care and treatment not holistic
- Improvements in practice & services needed

Details of Research Report

- Ridley, J., Rosengard, A., Hunter, S., Little, S., with Cummings, L., Edkins, V., Fallan, F., Laird, T., McLaughlin, A., Muir, J., Thomson, A., & Whitelaw, J. (2009), *Experiences of the early implementation of the Mental Health (Care & Treatment) (Scotland) Act 2003: A cohort study*, Scottish Government. (Web only) www.scotland.gov.uk/Publications/2009/05/061558131/2