How well is the 2003 Act working?

Evidence from the Mental Welfare Commission

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Is the 2003 Act working as intended? An approach:

1. Are the Millan principles being respected?
2. Lessons from civil detentions on the Act in operation?
3. Availability of decision making supports; universal access to advocacy; widespread use of advance statements?
4. Are safeguards operating effectively and consistently?

The Millan principles – are they respected?

- Equality (Bansal, 2014- 4.8x higher rate of detention on CTOs for black people in Scotland; SIMD modelling on YP detentions, MWC October 2020)
- Respect for diversity (but e.g., even the forms could do with a refresh)
- Respect for carers (Carers' experience of interaction with services, MWC 2020)
- Benefit
- Participation
- Non-discrimination
- Child welfare (CAMHS wait list; inappropriate settings of care)
- Informal care (where possible) (note (Atkinson 07, Carswell 07 (in Lyons 2008) on impact of Act on informal patients (Tribunal working as intended?)
- Least restrictive alternative (limit breach of autonomy to minimum necessary- Setting of care?, **Proportionality?**
- **Reciprocity**

Has reciprocity found expression?

- What the Millan Committee said:

  *Where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a **parallel obligation** on health and social care authorities to provide safe and appropriate services, including ongoing care following discharge (p19,New Directions)*

- What the Act says:

  *'…**regard to the importance** of the provision of appropriate services to the person who is or has been subject to the certificate or order….'*

  s1(6)

Mind the Gap: Rights & Justice

- **In the gap e.g.,:**
  - YP detention; Perinatal monitoring;
  - People whose discharge is delayed from MWC reports:

    No through road (LD) (2016)- 1/3rd

    Autism& complex care needs (2019) – ½

    Scotland's mental health rehabilitation wards (2020) - 1/3rd

    Forensic Report (Medium and Low secure) (2017) : 61 people in LS

    More generally, the lack of resources to deliver the highest level of care that we aspire to.

Rights & justice- 2

- **Do principles translate to justiciable rights for individuals?**

  - MHTS Recorded matters (s64 (4) (ii) specify services, treatment etc.,

    Commission monitoring of this in 2009, 2013- patchy- lack of awareness from patients and named persons;
  - Commission powers ?
  - (Cf 117 after care in England and Wales)
  - Concern re: resources being directed by the courts?

  cf, Excessive security: A qualified success? (Ending 'entrapment' based on Least Restrictive principle- Millan p337)

- **Distributive justice and the pandemic.**

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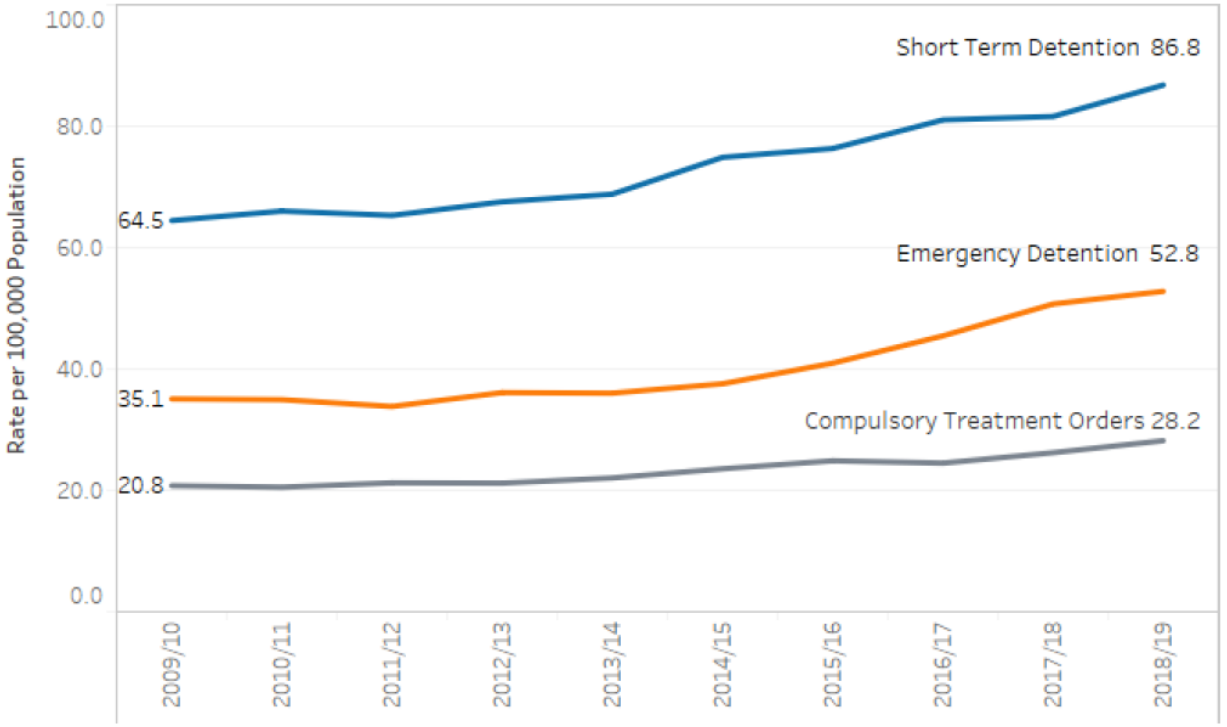
Detentions at highest level since Act came in

NB, A term of reference for the SMHLR is why the rising rates; and why the large geographical variation in the use of the Act

Figure 3.1: New orders across Scotland (rate per 100,000 population)



Evidence from EDCs

- EDCs and geographical variation- (note Palin 2019 on this: service factors, rural & remote vs urban)
- Millan expectation would be that EDCs would be used ‘sparingly’ (Lyons 2008); SG Quality Indicators (MH Strategy 2017- 2027) as EDC rate being an inverse marker of quality
- STDCs are the preferred route into hospital; Act commenced 46% of EDCs started in community- now 34%, gradual decline)
- Expectation was that EDCs without MHO consent would be rare (but EDC with MHO consent 5 year average 53%; (pandemic 45%) (MHO role and importance of different professional values)

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Evidence on STDCs (unpublished data from the Commission)

- 40% rise in STDCs since Act started (some groups more); significant variation
- 2005-2019 = 47,330 STDCs
  - 40% went onto CTO;
  - 39% revoked before 28th day (distribution on next slide);
  - 21% lapsed/revoked on the 28th day (s49 duty)
  - ‘’…The use of the Act is reflexive’ IRMHA p120

  White paper: increase safeguards

  Excluding the 28th day lapse, average LoS on STDC is 14 days (Implications?)
  - Also cf, NZ 1992 Act, different time frames, 5, 14, 6 months.

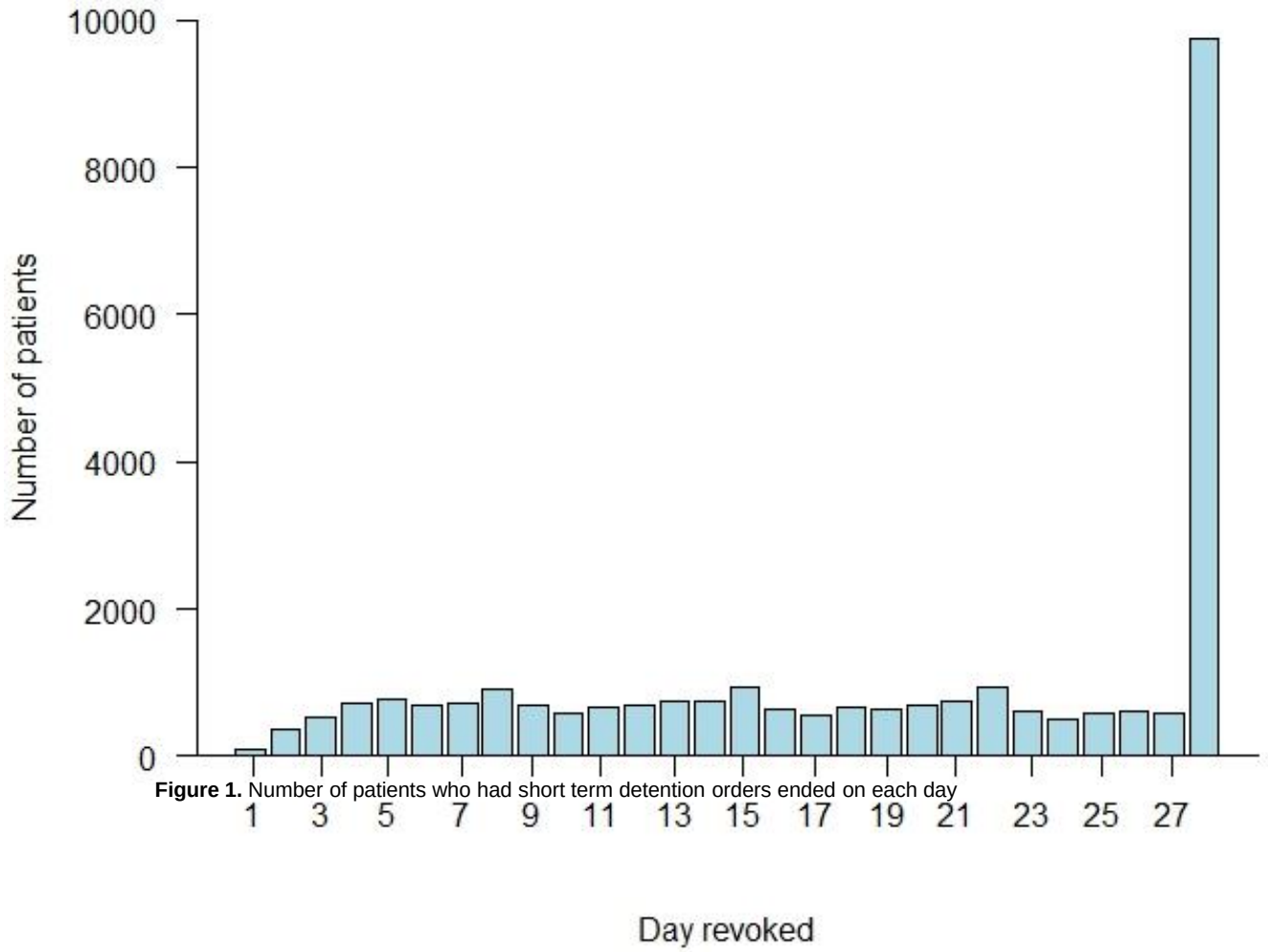

Figure 1. Number of patients who had short term detention orders ended on each day

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STDCs, equality and proportionality: *unpublished preliminary analysis*

- Being black; being male; and increasing age are statistically significantly associated with longer STDCs (equality principle)

- Service models and culture matters: statistically significant variation between the top 10 admitting hospitals on likelihood of 28th day revocation and duration of STDCs.

- Days of the week make a statistically significant difference; most likely to be admitted on a Friday; Monday most likely for discharge; very very unlikely to get discharged at a weekend; weekly ward rounds seem to exert an effect.

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Evidence on Compulsory Treatment Orders

- Significant regional variation
- Prevalence of CTOs has risen, largely driven by the 56% increase in prevalence of cCTOs
- Scottish Exec estimate at any one time, about 200 people would be subject to a cCTO(Kings Fund, 2006) OCTET ; currently about1800 people
- Burns et al 2013, no difference in readmission from CTOs- OCTET;
- Taylor et al 2016, Scottish study, did show savings on bed days (66-39)
- Length of an ‘average’ CTO = 501 days
- Are principles of Least restrictive; informal care, engaged here?
- Commission visit on people on CTOs recommended a ‘revocation strategy’ but should law development go further ‘sunset clause’?

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Positive Safeguards: Evidence on Advocacy- March 2018

- S259 introduced a duty on services to ensure availability of advocacy and a right to Individual advocacy.
- Individual advocacy is widely available (collective advocacy; non instructed advocacy less so)
- Most services prioritising referrals for people subject to MHA
- Significant gaps in provision for children and young people
- Lack of attention to equalities (cf., UK White Paper, ‘pilot culturally specific advocacy’, amongst other interventions to tackle racial inequality entrenched)

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Positive Safeguards: Advance statements (not there yet…)

- legal duty to pay attention to wishes expressed when well(s 275)
- Register established in 2015 Act
- AS registered with MWC is a QI indicator for SG
- 2018/19 – 271 returns (253 people) – none in Borders, 1 in A&A; 2 in Highland – so still minority interest
- **Prevalence Study – *(*Ross, *in draft, preliminary data)* detained patients (visited by DMP for authorising treatments on T3s) = 6.6% (f>m ASO%)**

(cf, English study we found 4% use (Morriss et al, 2017)

- Issues: Awareness & mechanism to create, too broad in content?, limitations of retrospective scrutiny?
- Pandemic attention on advance planning provides opportunity to address

Part 16 safeguards & The role of the DMP

- The system works
- CQC- SOAD ‘challenge rate’ 27%; (our ‘change and challenge’ rate around 12% but is that a meaningful metric?)
- Much discussion took place before the Appendix E was actually written. The ‘new’ electronic form to request a DMP will help with this.
- New roles? What should attract safeguards?

  (cf, White paper recommendations)

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Best Practice, ‘The SIDMA question’ & ‘Fusion’

- Millan Committee concerned about capacity test, hence SIDMA introduced but remained undefined. Unique.
- Shek (2010) recommended full descriptions of SIDMA. 50% said lacks insight. Commission guidance on SIDMA recording (2014, reviewed 2017).

- Brown (in draft) SIDMA recording – Only 12 out of 100 forms recorded the actual symptom that led to the impairment of decision making. Many forms just said ‘inconsistent’, insightless (81); mentioned a diagnosis.

- Should SIDMA be retained: with better training?; jettisoned in favour of capacity? Or something else? Implications for fusion? Join with the AWI?

Finally, on governance mechanisms…

- Act sets up the MWC

- Final report of the Independent Inquiry into Mental Health Services in Tayside https://independentinquiry.org

  ‘A national review of the assurance and scrutiny of mental health services across Scotland, including the powers of Healthcare Improvement Scotland and the Mental Welfare Commission for Scotland.’

- Options – Role: NPM vs broader? Core constituencies? Powers?

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