

Health and Community Care

Experiences of the Early Implementation of the Mental Health (Care & Treatment) (Scotland) Act, 2003: A Cohort Study

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This evaluative research study was commissioned to explore the implementation of the Mental Health (Care & Treatment) (Scotland) Act 2003 (MHCT Act). A team of independent researchers including 8 mental health service users undertook the study, which lasted 2 years from September 2006. Using qualitative methods, the experiences and viewpoints of those subjected to compulsory care and treatment, of informal carers and families, and of a range of health and social care professionals and advocacy workers were explored in-depth. The findings should be read within the context of the research study undertaken, and care taken in generalising to different populations and areas.

Main Findings

- This study found evidence of positive shifts in practice, in service cultures, and in the approach to detention, as well as of scope for increased consistency and improvements.
- Mental Health Tribunals were viewed by all stakeholders as an improvement, which provided increased opportunity for participation, although personal experience did vary.
- Few service users had either made an Advance Statement or were considering making one, and many saw little point in doing so as they believed this would inevitably be overridden.
- The named person role was complex and often poorly understood by service users and many professionals. Although bringing about improvement for some carers, this was not universal.
- Challenges to implementing the Act's principles, particularly the 'least restrictive alternative' and 'reciprocity', were often linked to gaps in the range of community resources.
- There were indications that resourcing of new roles, responsibilities and processes arising from the MHCT Act was having a detrimental impact on the delivery of other mental health services and the de-prioritisation of those not under compulsory measures'
- Despite some efforts to address the difficulties, there was still confusion and uncertainty among many professionals about overlapping legislation regarding the notion of capacity.
- Although universally unwelcome at the time, just over half of the service user sample reflected up to one year later that compulsory care had been right for them at the time, even those detained in hospital.
- At the time of the research, new community-based compulsory orders appeared limited in use and scope, in some cases equating to medication orders.
- Although some service users had positive experiences, there were gaps in support for wellbeing and social development generally including little encouragement to take up employment.

Introduction

This study looked in-depth at a range of experiences and perspectives on the implementation of the MHCT Act. The study's main aim was to evaluate these experiences and views against different stakeholders' perspectives expressed prior to implementation. In summary, its objectives were to:

- Identify and describe the operation and impact of the MHCT Act in practice;
- Examine in detail the service journeys of a sample of mental health service users over one year;
- Examine the interaction of different parts of the legislative system;
- Assess the success of measures to promote well-being and social development;
- Evaluate the implementation of the Act against the Millan Review principles;
- Recommend how all stakeholders' experiences can continue to inform future development of mental health law.

The research focused upon individual accounts of the different stages of compulsion, rather than on in-depth case histories, which it was decided could be too easily identifiable.

New roles and responsibilities

Not all the early concerns of professionals were borne out in practice. For instance, GPs' workloads were only marginally affected, if at all, whereas the role and responsibilities of psychiatrists and Mental Health Officers (MHOs) were significantly changed by the Act.

A key concern identified by this study, as well as from consultation conducted prior to the Act's implementation, was the impact of new professional roles and responsibilities under the MHCT Act on the wider system of mental health services.

Others concerns that workload implications and bureaucracy, such as those arising from the Tribunals, would impinge on professionals direct time with patients/clients as well as on their wider preventative role, were borne out in practice. There were indications that the focus on meeting the requirements for compulsory care and treatment under the MHCT Act were at the expense of the broader development and effective delivery of mental health services generally.

Predicted shortfalls in independent advocacy to meet anticipated need did not appear to be realised in practice. Service users had been able to access advocacy support when they wanted to. However, concerns were expressed about the danger of professionalisation of advocacy, with this becoming 'just another service'.

Journeys through compulsion

Given that compulsory care and treatment by definition is an extreme form of control and constraint, it is perhaps not surprising that those interviewed did not universally welcome it. While over half (52%) believed in retrospect that compulsion had been the 'right thing' at the time, a substantial proportion (42%) consistently resented the loss of civil liberty, and considered compulsion to be an infringement of their human rights. They were especially dissatisfied with experiences of hospital-based compulsion.

People's pathways through compulsion were exceedingly varied, although there were some common themes. The lead-up to compulsion invariably included one or more of the following - self-neglect, strange or odd behaviour, non-compliance with treatment, transfer from prison, or anticipated risk based on past events. For a minority, this was their first experience of compulsion, whilst many had previous experience of mental health services and of hospital detention. Compulsion is not something that anyone chooses freely or which is perceived to be under individual control. It therefore provides a fraught context for interaction between service users and professionals.

The findings indicated that while there has clearly been general improvement in hospital-based psychiatric care, some concerns remain. Service users and carers reported poor physical conditions on some hospital wards and in some hospitals, while others had undergone radical upgrading. Commonly, service users highlighted the boredom of hospital days, and resented the restricted opportunities on more secure or locked wards. Staff attitudes and the behaviour of other patients had a significant bearing on people's perception of hospital-based compulsory care.

The picture painted of community-based compulsory care was complex. Approximately one third of the study sample referred to their recent experience of compulsion as being community-based. However, some were in fact under suspended hospital-based orders. Many were unclear about exactly what orders they were under. The assumption that being treated in the community is preferable was not entirely

supported by service user opinion. Although regarded as a positive innovation generally, the limits on autonomy, choice and control of any form of compulsory care were resented, regardless of whether this was community- or hospital-based.

The concepts shaping treatment under compulsory care emerged as an issue deserving of further investigation. Indications were of care and treatment regimes based upon the individual or medical model, with less attention being paid to psychosocial explanations and alternatives to conventional drug therapies. Experience showed less attention being paid to broader issues that would aid and support recovery. Shortfalls in services and support e.g. psychological therapies, has already been recognised by the Scottish Government, which is currently addressing this agenda through service developments identified in its *Delivering for Mental Health* commitments.

Interaction with other legislation

The research findings point to a degree of uncertainty among some professionals in applying overlapping legislation in respect of incapacity. Despite being an area that the Scottish Government and the Mental Welfare Commission for Scotland were actively addressing at the time of the research, professionals identified this as an area of confusion and frustration, and as requiring specialist training input. It is likely that measures implemented since the research will have alleviated some of these concerns.

Social development

Many service users and carers were unaware of what services were available to them in their communities, including what support there was for leisure and employment. Opportunities to access information as well as specialist support for employment were not equally accessible in all parts of Scotland. Previous research has found a lack of employment support generally for people with mental health problems. Despite research suggesting that a return to work or gaining employment is the most significant factor in people's recovery, promotion of employment opportunities to those subject to compulsion appeared to be practically non-existent.

Some personal accounts highlighted the difference decent housing and support can make to recovery, not only to the individual but also, to the carers or family who are supporting them. The findings emphasised the importance of considering housing needs in hospital discharge planning. The research also highlighted that a range of housing options will be required to suit different needs.

Implementing the Millan Review principles

The MHCT Act set a more positive value-based framework for increasing user rights and improving compulsory care and treatment, along with systematic scrutiny. The research findings indicate a high level of awareness of the principles of the Act and active attempts to engage with them despite difficulties. A number of challenges were identified, by professionals especially, to implementing the principles of 'least restrictive alternative' and 'reciprocity' when community resources were scarce or under-developed. Gaps in community resources such as in community-based psychology services were reported to be affecting the frequency and scope of community-based compulsory orders.

Carers' experiences of being consulted and included whilst supporting their relative under compulsory care were variable and inconclusive. While some felt that Principle 7 of the Act, emphasising that 'informal carers should receive the advice and support they need and have their views heard', and new provisions such as the named person role had brought new rights, these could be denied if their status changed from named person to carer. The findings support other studies that point to a policy-practice gap in regard to recognition of the role of carers.

Principle 6 of the Act states that people should be involved as far as they are able to be in all aspects of their care, treatment and support, that their past and present wishes should be taken into account and they should be provided with information and support to enable them participate fully. This study indicates that the voice of the user is beginning to be heard through deliberately inclusive processes such as Tribunals and Advance Statements, the right to access independent advocacy and services' use of consultation mechanisms. However, while there were increased opportunities to voice their opinions, service users did not always believe that they were being heard. This was particularly evident in opinions about, and the low uptake of, Advance Statements.

Implications for future development of mental health law

It is critical that service user, carer and various professional perspectives continue to influence the development of mental health law, whether it is through research such as this, or one-off and ongoing consultation mechanisms. The challenges to involving the range of service users and carers need to be acknowledged, as do the resource implications of supporting meaningful support mechanisms.

Implications for future research

The findings from this study point to the importance of future research into a number of areas including:

- The effectiveness and outcomes of community-based orders;
- Outcomes of Tribunal hearings
- The quality and inclusiveness of care plans
- The employment support opportunities available to those under compulsion
- The housing needs of those under compulsion and how these are being met
- Research into the care and recovery pathways of specific groups e.g. those with complex needs, people with learning disabilities, people from BME communities
- Action research into effective ways of promoting Advance Statements.

Research methods

The research design was qualitative and participatory and was conducted in 2 stages across 4 different research sites – Dumfries & Galloway, Fife, Greater Glasgow, and the State Hospital. In addition to a literature review, which examined the research context and stakeholder views and expectations prior to implementation, the main data collection methods at each stage were:

Stage 1:

- Interviews with 15 professional or interest groups
- Interviews with 23 practitioners and advocacy workers
- Individual interviews with 49 service users
- Focus groups and interviews with 21 informal carers/relatives

Stage 2:

- Individual interviews with 39 service users from Stage 1
- Focus groups and interviews with 20 carers/relatives

Service users were involved in the research from the outset as research partners, in the development of the research design, drafting research protocols, identifying the research questions, as co-interviewers, and had an input into data analysis and the identification of key themes. The accounts of those experiencing compulsory care and treatment were a central part of the study.

This document, along with full research report of the project, and further information about social and policy research commissioned and published on behalf of the Scottish Government, can be viewed on the Internet at: <http://www.scotland.gov.uk/socialresearch>. If you have any further queries about social research, or would like further copies of this research findings summary document, please contact us at socialresearch@scotland.gsi.gov.uk or on 0131-244 7560.



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