mental welfare commission for scotland

Research brief
5 (March 2022)

How do DMP assessments affect patients' treatment plans?

Commission's placement scheme for higher trainees in psychiatry

The Mental Welfare Commission hosts a training placement for higher trainees in psychiatry in their final year of training before being eligible for consultant psychiatrist roles. As part of their placement trainees are encouraged to work on a project of their interest that aligns with the priorities of the Commission. This report arises from the work of a trainee on placement, supported by Commission staff.

Executive Summary

Designated medical practitioners (DMPs) are appointed by the Mental Welfare Commission for Scotland to assess, and where appropriate, authorise certain treatments requested by the responsible medical officer (RMO) for people subject to compulsory treatment under the Mental Health (Care and Treatment)(Scotland) Act 2003 who do not or cannot consent. We found that DMPs made changes to the requested treatment plan in 47% of the cases they assessed. After excluding for changes that involved the addition of 'safety wording' to treatment plans and looking at changes to actual treatment, the level of change remained high at 36.9%. People with more complex difficulties (multiple diagnoses) were more likely to have changes made to their treatment plans. There was no significant difference to changes made by age or gender. The majority of changes that DMPs made were to medication, most commonly adding in certain medications to the authorised treatment plan or removing medication. A quarter of DMP changes to medication involved removing certain medication, most commonly sedative medication and antipsychotic medication. A third of the removals were to remove intra-muscular medications (IM) from the treatment plans requested. During the Covid-19 pandemic DMPs were more likely to make changes to RMO treatment plans. The Commission appointed DMPs are undertaking vital patient safeguarding work. The DMP safeguard is one of the most tangible of the legal safeguards for those who cannot or do not consent to compulsory treatment.

Background

The Mental Health (Care and Treatment)(Scotland) Act 2003 sets out a number of safeguards for patients subject to compulsory measures.(1) One of these is the requirement that certain treatments – for which the person subject to compulsory measures does not or cannot consent – should be authorised by a designated medical practitioner (DMP). DMPs are experienced psychiatrists, who are appointed by the Mental Welfare Commission for Scotland ("the Commission") and receive specific training and participate in an annual seminar led by the Commission that aims to support them in undertaking this important role. They do not work at the same hospital as the responsible medical officer (RMO) and the patient being assessed in order to ensure an independent assessment takes place.(2)

Proposed treatment plans that require DMP authorisation are documented by the RMO using a second opinion request (SOP) form – (or Appendix E form prior to 1 August 2020[i]) – which is submitted to the Commission with a request for a DMP assessment. The role of a DMP is to assess patients and decide whether the treatment plan proposed by the RMO is both lawful and of benefit to the patient. They then

provide documentation of their assessment (Appendix A) and an authorised treatment form (T3). (2) For simplicity Appendix E/SOP forms will be referred to as "request forms" and T3 forms as "treatment forms" hereafter.

In Scotland, there have been, on average, 2000 DMP assessments each year since 2016. Over the last 10 years the number of DMP assessments has doubled; this is in line with the increased use of the Mental Health Act in Scotland during that time. Recent figures from the Commission and the Mental Health Tribunal for Scotland (MHTS) show a 45% increase in the number of detention forms being processed and a 29% rise in tribunal hearings over the same time period. (3,4) DMPs receive a standard fee for each assessment they carry out which is in line with the medical pay circular and is currently linked to the 'exceptional consultation' fee[1] undertaken by a consultant doctor at £179.86. (5)

The Commission is keen to further explore the safeguarding role of DMPs to understand what impact their assessment has on the initial treatment plans submitted by RMOs. One way to do this is to look at the changes made to the proposed treatment plans set out in the DMP request forms following the DMP assessment and contained in the treatment forms that are issued. We refer to this as the 'DMP change rate'.

The Scottish Mental Health Law Review (SMHLR) is currently ongoing. The principle aim of the SMHLR is to improve the rights and protections of people with mental disorders and remove barriers to those caring for their health and wellbeing[2]. The increasing number of DMP assessments and the current landscape of mental health law reform in Scotland provides opportunity for change and improvement. In this context, we felt it was important to explore the impact DMP assessments have on patients' treatment by examining change rates and looking in detail at the types of change made as well as identifying possible contributory factors to these. We therefore conducted a study focusing on three key questions:

- What is the change rate following a DMP assessment?
- When changes are made are there common themes that arise for example, changes to certain types of medication (such as emergency sedation) or availability of 'as required' medication?
- Is there any correlation between DMP changes and patient variables such as age, diagnosis, or health board?

[1] For interest and cross comparison, the current set fee for an equivalent patient visit by a Second Opinion Appointed Doctor (SOAD) in England is set at £200.
[2] Home Page of the Scottish Mental Health Law Review Homepage | Scottish Mental Health Law Review (accessed 29 January 2022)

What we did

The Commission had previously undertaken scoping work on DMP change rates in 2019[3]. We used this initial work as a framework for this study. We looked at 400 patient records, which represented approximately 10% of all DMP visits from 2019-2021. We wanted our sample to be representative of all patients visited by DMPs, so we sampled 400 patients proportionally similar in age, sex, health board, and treatment requested (medication, artificial nutrition, ECT or medication to reduce sex drive) to the total population of patients visited by DMPs from 2019-2021)[4]. We also recorded patients' diagnoses where these were available.

We compared the request forms provided by the RMO, the Appendix A (a record of the visit that the DMP provides to the Commission) and the treatment form issued by the DMP after their visit. If no request form was available then we looked for evidence of change in the DMP's Appendix A. We excluded any records where none of these forms were available.

We used the following approach to analyse the information provided. First, we noted if a change had been made, then categorised this by the type of change: medication change, ECT change, or wording change that altered the scope of the treatment plan. If treatment forms had multiple changes then these were all recorded separately. Secondly, we looked at the details of the change within each category, and finally, we recorded what the specifics of these were. The coding framework used is summarised in Table 1 below. Data was analysed in Microsoft Excel, using descriptive statistics.

Change present	Type of change (1)	Categories (2)	Object changed (3)
Yes	Medication	Altered dose	Emergency Sedation Anxiolytic Antidepressant Hypnotic Antipsychotic Other
		Added medication	
		Removed medication	
		Authorised HDM[1]	
		Did not authorise HDM	
	ECT	Altered treatments	
	Wording	Specified drug (rather than a class)	
		Broadened options[2]	
		Safety Wording[3]	Physical monitoring ECT Medication usage Review requirement Other advice

Table 1: Categories for change(s) made by DMP to Appendix E/SOP treatment plan.

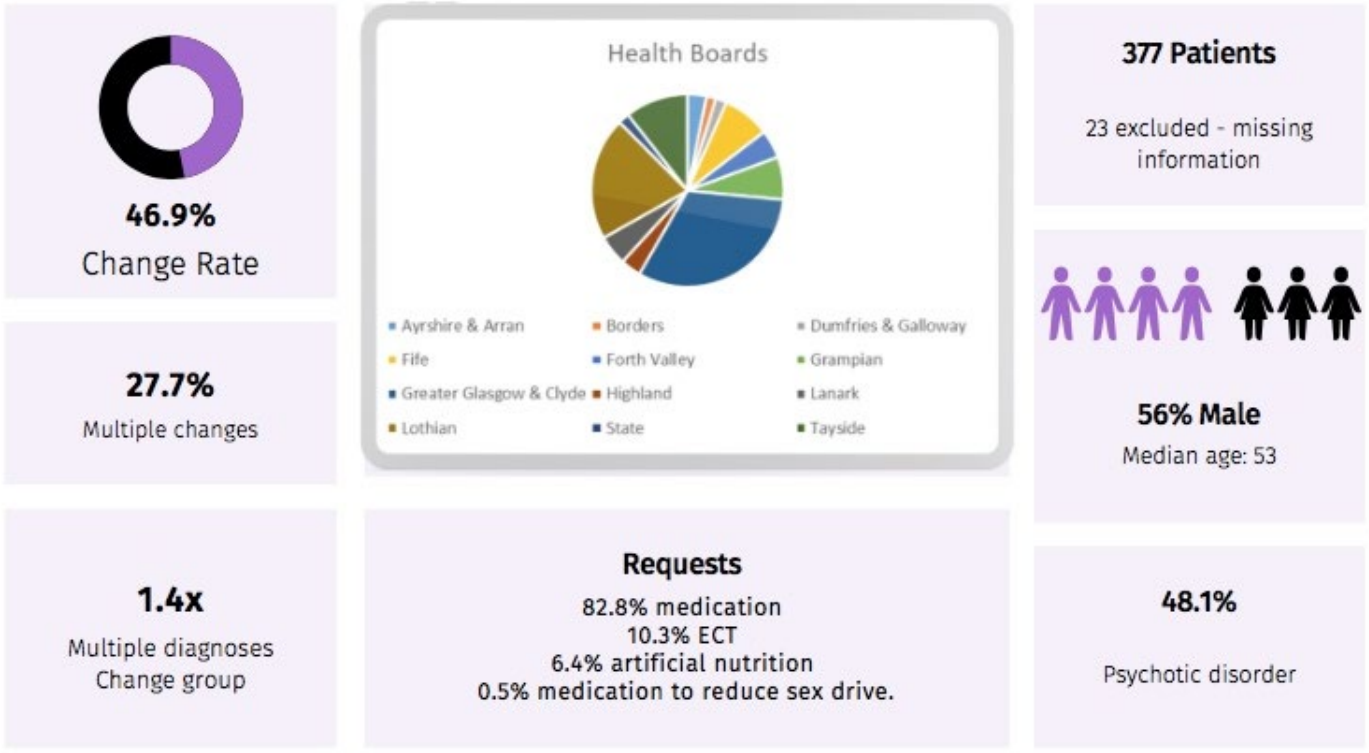
[1] Authorising High dose monitoring is to allow antipsychotic doses above British National Formulary (BNF) maximum limits of medication to be used with appropriate monitoring to be prescribed.
[2] Replacing a specific agent with its drug class e.g. zopiclone vs. hypnotic.
[3] This category encompassed any additional wording on the treatment form that either provided treatment advice or imposed restrictions on the treatment plan.

[3] The Commission wishes to acknowledge the work of the then higher trainee on placement, Dr Anna Fletcher, for the initial scoping work.
[4] We used stratified randomisation to create the sample.

What we found

The key characteristics of our sample are shown below in Figure 1. In total we coded 377 patient records, with 23 excluded due to lack of request form and/or Appendix A availability. The median age of patients was 53, and 56% were male. The majority (312; 82.8%) of requests were for authorising medication, 39 (10.3%) for ECT, 24 (6.4%) for artificial nutrition and <5 (0.5%) for medication to reduce sex drive. A primary psychotic disorder (e.g. schizophrenia, schizoaffective disorder) was the most common diagnosis (48.1%) and the majority of patients came from NHS Lothian and NHS Greater Glasgow and Clyde health boards.

Figure 1: Summary of Key Population Characteristics



Change Rate

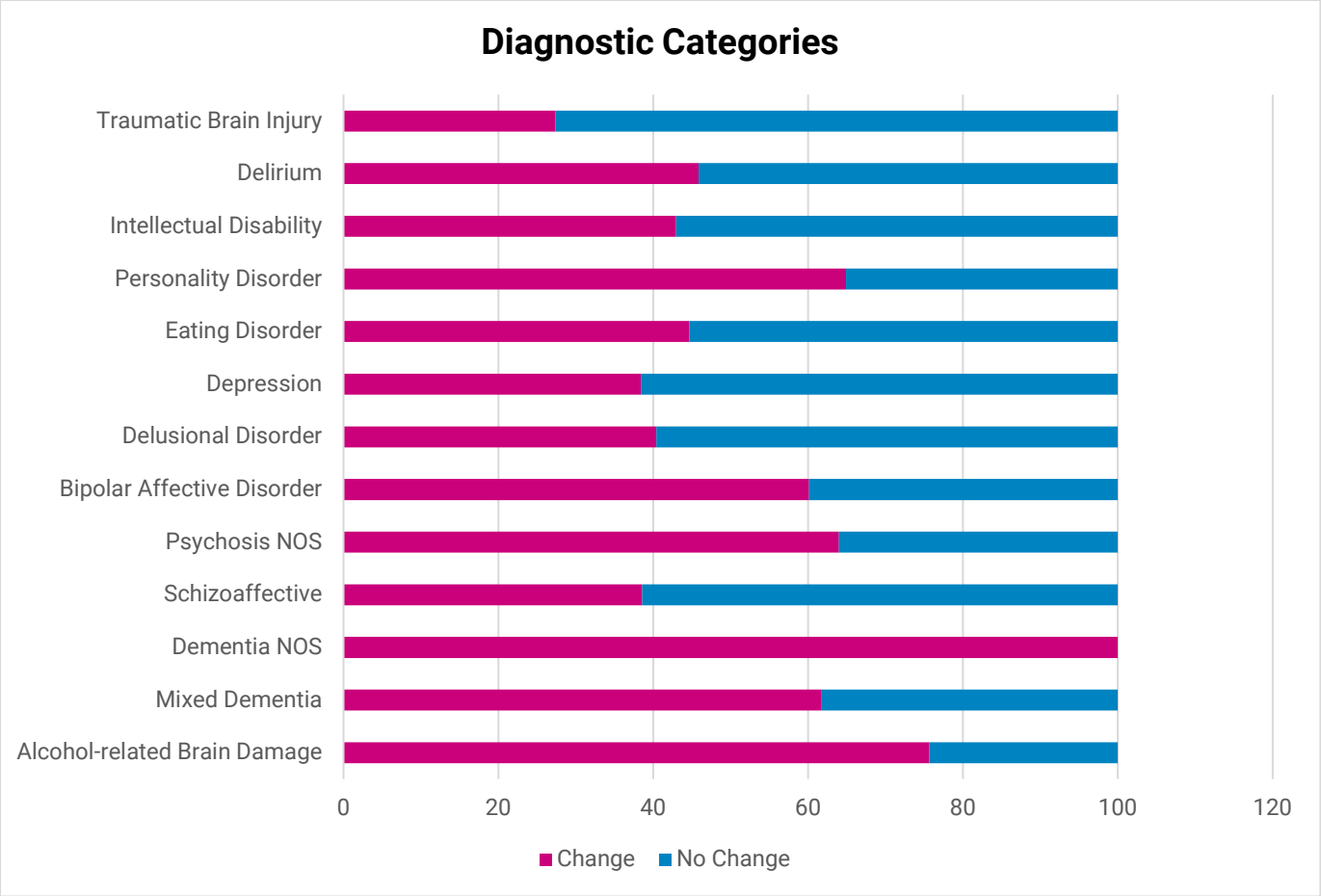
A total of 177 (46.9%) treatment forms (T3s) for patients showed changes when compared to initial RMO request forms. We named this group the “change group” and the remaining 200 patients (53.1%) the “no change” group. Just over a quarter (27.7%) of the “change” group had multiple changes made.

There was no significant difference in patient age or gender between the “change” vs. “no change” groups.

Patients in the “change” group were 1.4 times more likely to have multiple diagnoses, and certain diagnostic categories were more prevalent in one group vs the other. These are shown in Figure 2 below. In particular, alcohol-related brain damage (ARBD), personality disorders and “non-specific” diagnoses, such as unclassified psychosis or dementia, had a higher representation in the “change” group.

The other significant difference between change rates was seen when the groups were divided into “pre-COVID-19” (n=180; 47.4%) and “during-COVID-19” (n=197; 52.3%) groups. The date for inclusion in the ‘during-COVID-19’ group was taken as the start date of the first lockdown in Scotland on 23 March 2020 as a public health response to the pandemic. The pre-COVID group had a change rate of 37.8% whilst the during-COVID-19 group had a change rate of 55.3%.

Figure 2: Proportional representation of diagnostic prevalence in Change vs. No Change groups



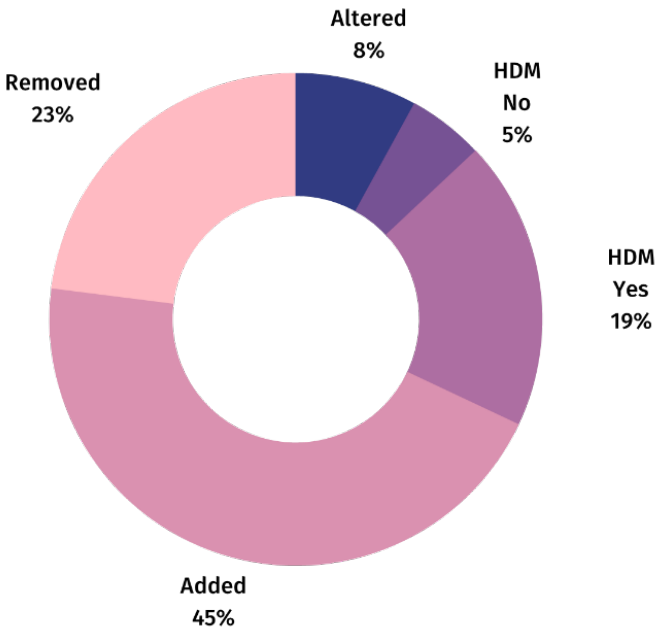
NOS: Not otherwise specified

Medication Changes

The majority (80.2%) of changes made by DMPs were to medication.

These are shown by category in Figure 3 below. Adding in medication to the authorised treatment plan was the most common change; the majority of these were for 'as required' medication for emergency sedation (39.8%) or antipsychotics (24.3%). Changes to emergency sedation included adding additional medication options, such as an anxiolytic or sedative, or an alternative form of a medication already prescribed e.g. the option to use an intramuscular (IM) variant. In our sample, 24.4% of emergency sedation changes were adding in IM midazolam as a lorazepam alternative, due to shortage of UK supply of the latter. The majority of antipsychotic additions were either authorising a depot formulation or adding an oral antipsychotic for cross titration or augmentation.

Figure 3: Changes made to medication



Emergency sedation (13.6%) and antipsychotics (36.4%) were also the most common medications removed from the original treatment plan**. IM medication made up 29.5% of drugs removed; this included IM emergency sedation options and depot antipsychotics**. In 19% of cases the DMP chose to authorise HDM (high dose monitoring and prescription of antipsychotics) when it had not previously been requested; it was comparatively rare, in only 5% of cases, for DMPs to refuse a request for HDM.

Wording

Significant changes to wording were found in 35% of the "change" group. 60.6% of these were the addition of safety wording to the treatment form. This category encompassed any additional wording on the treatment form that either provided treatment advice or imposed restrictions on the treatment plan. Some of these were standard safety phrasing repeated on multiple treatment forms, as is shown in Figure 4 below; these were usually in relation to artificial nutrition or ECT. Half of all safety wording related to the use of medication. Almost a third (31%) of these were advice about haloperidol and the recent change to guidelines for its use in combination with other antipsychotics. The remainder focused on how medication could be used, for example: stipulating two sedatives should not be used together or specifying an oral antipsychotic could only be used for three weeks for cross titration purposes.

Figure 4: Example of standard phrasing for safety wording in artificial nutrition.

> *"Artificial nutrition must be prescribed with advice from specialist dietician as part of care plan. It may be given if the patient does not comply with meal plan.*
>
> *The patient should be regularly offered food and drinks, including nutritional supplements, as part of a care plan aimed at achieving healthy patterns of eating and drinking.*
>
> *The NG tube must be inserted and feeds administered by suitably trained staff. It must have its position checked routinely by measuring aspirate pH and x-ray if necessary.*
>
> *Minimum necessary physical restraint and oral sedation may be used to facilitate safe insertion of tube and administration of feeds. The patient's physical condition must be monitored in accordance with MARSIPAN and local clinical guidelines."*

The other significant category of wording change was the specification of types of medication on the treatment form, in 27.3% of cases. It included specifying a particular medication (e.g. diazepam) or specifying a particular class of drug (e.g. benzodiazepine) when the initial RMO treatment plan had requested authorisation of a broader range of options. 73.3% of these specifications related to requests for anxiolytic or sedative medication. In just over half (54.5%) these terms were replaced by a specific medication e.g. promethazine, diazepam or propranolol. In the rest the drug category was narrowed e.g. 'anxiolytic' was replaced by 'benzodiazepine'.

ECT

The final area of change was alterations to requested ECT treatment. The safety wording applied to treatment forms for ECT has been covered above. In our sample only 5% of treatment forms amended dose of ECT; in all cases this was authorising an acute course of 12 sessions, but not authorising maintenance treatment beyond this.

What this means

'The DMP change rate'

We completed this study to explore the change rate in treatment forms after DMP assessment. Our change rate of 46.9% is higher than we expected. This is the first attempt to quantify the change rate following DMP assessments in Scotland.

There is very little data from other jurisdictions that can be used as a comparator. The Mental Health Act (1983), which applies to patients in England and Wales, has a similar role called a 'second opinion appointed doctor' (SOAD). (6) The Care Quality Commission (CQC), who appoints SOADs in England, reported a change rate of 23% in 2020. The CQC change rate is based on a SOAD's individual assessment of whether they made a change to a treatment plan. SOADs are given guidance in their initial training on what constitutes a change. The changes measured are only those made to medication – including high dose monitoring – and do not include the addition of safety wording. (7)

Even when we remove all changes aside from those to medication, however, our change rate falls to 36.9%, which is still considerably higher than the CQC reported figure. One possible explanation for this might be that the CQC change rate is self-reported by the SOAD, whereas our study measured the change rate independently. In previous discussions with DMPs, they have intimated that they see certain alteration that they make – safety wording, medication suggestions, duration of use – as an essential part of their job, rather than an addition or change.

The change rate was significantly higher during the pandemic but the reasons for this are unclear. DMP assessments were undertaken virtually at points during lockdowns, and initially there was a greater waiting time between requests and visits, which may have led to more treatment plans being changed by RMOs whilst awaiting a DMP review. During the lockdown period, there was also a tendency to authorise treatment forms for shorter periods of time, as an additional safeguard; it is unclear whether this affected the change rate. It is possible that health board staffing pressures and redeployment strategies during the pandemic led to clinicians covering increased workloads and fulfilling the RMO role for additional patients, perhaps in services less familiar to them. DMP assessments in these circumstances may have been more likely to identify treatments that required some form of alteration.

Medication

The majority of changes were to medication. The DMP has played a vital safeguarding role – checking medication thoroughly, providing a second opinion to the treating clinician and making modifications. The safeguard appears to work well.

Wording

The second key area of change was to wording, and again this had a variety of different subcategories. Standard phrasing with safety conditions was used in multiple treatment forms. This was seen in all forms authorising artificial nutrition and ECT. This highlighted the difference in detail between RMO requests. The majority of ECT and artificial nutrition requests had this safety wording already written on the request form, which meant that the only treatment forms classed as a 'change' in this area were due to limited detail from the treating clinician. There were other types of safety wording seen on treatment forms, which were not common to all requests of a similar nature, and related to the DMP filling in the form. Some DMPs drew attention to guidance on medication or dosage, specified the medication to be used or its duration of use. These are valuable safeguarding additions to a treatment form, even if they do not constitute a specific change to a RMO's treatment plan.

‘Intangible aspects of a tangible safeguard’

We wish to acknowledge that there is also work outside the formal structures that this study does not capture. On many occasions a conversation with an independent senior psychiatrist outside the clinical team, who has listened to the person subject to compulsory measures, provides rich information, support and, at times, challenge that informs more than just the medical treatment plan. We note that the non-specific diagnoses of psychosis and dementia, in addition to ARBD and personality disorder were all more common in the “change” group. A commonality between these is that they lack a clear set of guidelines for treatment and, in the non-specific cases, suggest a level of diagnostic uncertainty which can indicate a complex patient presentation. A second opinion from an experienced independent psychiatrist might be particularly helpful in these cases, which also could influence the change rate shown. This aspect of the interaction between RMO and DMP and patient has not been studied.

Limitations

A limitation of this study is that we have not controlled for or studied DMP demographics such as years since qualification, years of experience of being DMP, sub-specialty of the DMP, gender, ethnicity, etc., which may also play a role in the change rate. We hope that with greater sophistication of our database (the Commission is currently in the process of changing the way it stores data) we might be able to work with partner organisations to consider further how these variables interact and thus increase the protection that this safeguard offers.

Finally, it is acknowledged that this is the first time that an in-depth comparison has been made between the initial requested treatment plan and subsequent treatment forms. This means that, while it provides an initial exploration of DMP assessments, it is more useful in identifying areas that could be studied in more detail rather than drawing firm conclusions. It is, however, clear that there are a variety of important practices undertaken by DMPs during their assessments and their work is instrumental in safeguarding patients subject to compulsory measures.

Acknowledgements

This work was led by Dr Alexandra Pittock, ST6 General Adult Psychiatrist while doing a traineeship with the Commission.

Why we wrote this brief

The Commission has a statutory duty to promote best practice in the treatment of people with mental illness. One way we do this is undertaking research and audits of our records, presenting the key findings and disseminating them to the public. This is presented in a summarised format here and provides an insight into a key safeguarding component of the 2003 Mental Health (Care and Treatment) Scotland Act.

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