

# The use of the Mental Health Act in elderly patients in one health district

C. Morris and I.M. Anderson

There has been little published on the application of the Mental Health Act (1983) in the elderly. We therefore surveyed its use in a district old age psychiatry service covering a mixed rural and urban population with about 60,000 people over 65 years. The MHA was applied 36 times to 32 patients over a two year period. The primary diagnosis was a functional psychiatric illness in 64% patients (usually depression) and dementia in 36%. Functionally ill patients were most frequently detained on a treatment section (S3) and demented patients on an assessment section (S2). Only one patient with dementia was placed on a guardianship order. The outcome of treatment is described.

The Mental Health Act (1983) (MHA) is a necessary part of treating older people with psychiatric problems but despite this, little has been written about specific difficulties in applying the MHA to the elderly. It would be a mistake to suggest that this is the result of uniformity in practice, indeed there seems little consensus across the country (or even within districts) about how the powers should be used.

Another legal power, section 47 of the National Assistance Act (1948), is not primarily concerned with mental health problems although studies indicate a high incidence of major psychiatric disorder (predominantly organic mental illness) in its recipients (Forster & Tiplady, 1980; Wolfson *et al.*, 1990). There are several difficulties in its use, including lack of legal protection for the subjects except through the courts and the vague wording of the Act itself. Most subjects appear to live alone and are removed from their own homes with little hope of return and the mortality is high (Forster & Tiplady, 1980; Wolfson *et al.*, 1990). It is possible therefore that the MHA may often be a more appropriate power to use, providing more protection of civil liberties and perhaps improving outcome.

We were therefore interested in the application of the MHA to the elderly. It has been reported that most of those subject to a guardianship order live alone and suffer from a chronic organic brain syndrome and that its use tends to be to

facilitate transfer to, or continuation of, residential care. While the outcome of its application is usually favourable (e.g. Wattis *et al.*, 1990), it is not used frequently and one criticism of guardianship is the doubt over whether a 'power to convey' is included. As part of an audit programme, we carried out a retrospective survey of how the MHA was used in a district old age psychiatry service covering a mixed urban and rural population with approximately 60,000 people over 65 years.

## The study

Patients placed under a section of the MHA by one of the three consultants in old age psychiatry or the senior registrar from January 1991 to December 1992 were identified, and their case-notes examined. Although some degree of functional and organic illness frequently coexisted, for the purpose of this survey patients were assigned exclusively to having a functional or organic illness depending on which was predominant. Outcome was assessed from case-note review and discussion with the clinician involved. A four-point clinical global impression of outcome was made: marked improvement (recovery or sufficient improvement to allow attainment of premorbid level of functioning), moderate improvement (significant alleviation of presenting condition sufficient to allow supported living in the community), mild improvement (some alleviation of presenting condition but continuing to need intensive nursing care in hospital or nursing home), no improvement/worsening (including death). The survey is descriptive but  $\chi^2$  tests are applied sparingly where they enhance interpretation of the findings.

## Findings

### *Patients and length of admission*

Thirty-two patients were admitted on section during the study period, 24 female and eight

male. The mean age was 80 years (range 70–96). The median length of admission was ten weeks; this was the same in the group of patients with functional illness (median ten weeks, range 2–47) and dementia (median 9.5 weeks, range 3–18).

### Sections

There were 33 admissions on section involving 32 patients. Of the 36 times the MHA was used, section 5(2) was used twice (6%, both for organic illness), section 2 on 15 occasions (42%, five for functional and ten for organic illness) and section 3 on 18 occasions (50%, all but one for functional illness). One guardianship order was completed (3%). Demented patients were most frequently detained under a section 2 and functionally ill patients under a section 3 ( $P<0.001$ ). On three occasions patients were transferred from one section to another (section 5[2] to 2, section 2 to 3 and section 3 to guardianship order).

The majority of episodes were admissions as the result of worsening of the mental state (18 out of 33; 55%), while in five cases (15%) physical decline resulting from a mental disorder was the major concern. In nine cases (28%), the patient was placed on section 3 before requesting a second opinion from the Mental Health Act Commission for ECT. In all cases the Commissioner agreed to the proposed treatment plan. The guardianship order was completed to facilitate transfer of a patient with dementia to a residential home.

### Diagnoses

The majority of patients (21 out of 33; 64%) had a primary functional illness (five had a paranoid psychosis, 13 a severe depressive illness, two mania and one a severe hypochondriacal disorder) with 12 patients (36%) suffering primarily from dementia.

### Admission and discharge

Eight-two per cent of patients (9 demented, 18 functionally ill) were living at home at the time of admission (17 alone, ten with a carer of whom three were dementing), and in five cases (15%) the patient was in residential care. One patient with a severe hypochondriacal disorder was admitted directly from a district general hospital.

Thirteen patients (39%) returned home, 12 (36%) moved into residential care for the first time and five (15%) returned to residential care from where they had been admitted. Three patients (9%) died, one with dementia and two functionally ill patients.

Ten of the 11 patients (91%) with dementia who left hospital were discharged to residential care compared with seven of the 19 discharged patients (37%) with functional disorders

( $P<0.01$ ). Of those entering care, the proportion who did so for the first time was comparable in the two groups (7 out of 10 demented patients v. 5 out of 7 functionally ill patients).

### Outcome

Five patients (15%) made a marked improvement, 17 (52%) a moderate improvement, five (15%) a mild improvement, three (9%) no improvement and three patients (9%) died. Of the functionally ill patients, five (24%) made a marked, and eight (38%) a moderate improvement. No demented patients made a marked improvement but nine (75%) had sufficiently improved behaviour or physical state, or both, to be considered as moderately improved and able to return to supported community living.

Of the nine patients prescribed ECT under section 3 with a second opinion, five (55%) had moderate or marked improvement, two (22%) showed only mild improvement and two (22%) died after transfer to the district general hospital for physical illness; one before starting ECT due to severe dehydration, the second as a consequence of a severe chest infection developing early in the course of treatment.

### Comment

This survey describes the use of the MHA in a district service. There is little dispute over the need for the MHA in some patients with functional disorders. While our measure of outcome was retrospective and limited and must therefore be treated with caution, it is noteworthy that while 62% of functionally ill patients made a moderate improvement or better, only 24% could be considered as recovered.

The place of the MHA in the management of patients with dementia is less clear. It has been said that sections 2 and 3 of the Mental Health Act are of little help in the elderly with dementia who are unable to live safely at home (Manger & Oppenheimer, 1989). However our survey shows that it is possible to use section 2 of the MHA to facilitate transfer from home to residential care. Once the patient is in hospital it has been our experience that a firm wish to return home is usually not expressed (contrary to the refusal to leave home voluntarily before admission) and, once the patient has been transferred to residential care, he or she has settled without major problems. The use of the MHA for this group of patients does depend on the psychiatrist, general practitioner and social worker working together in an agreed and flexible manner. Our findings do not, of course, preclude other ways of achieving the same clinical end without invoking the MHA, although the statutory safeguards of civil liberties embodied in the MHA arguably make its

use preferable to the National Assistance Act (1948), and to 'persuasion' or even deception that undoubtedly does occur in this difficult clinical situation.

However, it was not the intention for the assessment and treatment sections of the MHA to be used to facilitate residential care for patients with dementia, and controversy over the use of section 47 of the National Assistance Act (1948) and guardianship orders indicates that none of the available legislation adequately provides for this group. The recent Royal College of Psychiatrists' proposals for a community supervision order and the Department of Health's response (supporting greater use of guardianship orders, extended leave of absence on a section 3 and a new form of supervised discharge) is concerned primarily with ensuring the continuing psychiatric treatment of patients with recurrent psychotic illness following discharge from hospital (Bluglass, 1993). None of these proposals addresses the need of demented patients which is usually 24-hour social care rather than psychiatric treatment. One option would be a new 'care order' which would enable demented patients to be looked after more satisfactorily while still providing protection of civil liberties, but we suggest that it would be preferable for the role of the existing guardianship order to be extended and made more explicit. We believe this would lead to a greater consensus over the

application of legal powers to this very needy and extremely vulnerable group of patients.

### Acknowledgements

We thank Drs D. Rice, J. Helling and F. Fadl for allowing us to report on their patients and Sylvia Warwick for technical help.

### References

- BLUGLASS, R. (1993) New powers of supervised discharge of mentally ill people. *British Medical Journal*, **307**, 1160.
- FORSTER, D.P. & TIPLADY, P. (1980) Doctors and compulsory procedures: Section 47 of the National Assistance Act 1948. *British Medical Journal*, **280**, 739-740.
- MANGER, D. & OPPENHEIMER, C. (1989) Question of choice, consent or coercion. *Social Work Today*, **28**, 20-21.
- WATTIS, J.P., GRANT, W., TRAYNOR, J. *et al* (1990) Use of Guardianship under the 1983 Mental Health Act. *Medicine, Science and the Law*, **30**, 313-316.
- WOLFSON, P., COHEN, M., LINDSAY, J. *et al* (1990) Section 47 and its use with mentally disordered people. *Journal of Public Health Medicine*, **12**, 9-14.
- C. Morris, *Consultant in Old Age Psychiatry, St Andrew's Hospital, Yarmouth Road, Norwich NR7 0SS*; and \*I.M. Anderson, *Senior Lecturer in Psychiatry, University of Manchester Department of Psychiatry, Rawnsley Building, Manchester Royal Infirmary, Oxford Road, Manchester M13 9WL*

\*Correspondence

# Antidepressant prescribing among referrals to a community mental health unit in New Zealand

Robert J. Thomson

This study involved a case-note review of referrals to community psychiatric services in a university town in New Zealand. About one third of all 163 patients referred were taking antidepressants for depression; of these one third were taking therapeutic doses, with the remainder taking inadequate doses. This tends to confirm the findings of other studies that have identified problems relating to GP prescribing of antidepressants.

In the UK, increased interest in depression in the setting of general practice has led to the recent Defeat Depression campaign.

As long ago as 1973, the correct prescribing of antidepressants by general practitioners (GPs) was questioned with inadequate doses being one of the main problems. Johnson (1973) recommended that more active supervision of treatment was needed by GPs and a