The Mental Health (Amendment) Act 1982: Will it Make a Difference?

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An examination of the changes to be introduced by the Mental Health (Amendment) Act 1982 suggests that they might have a significant effect on the fate of many patients who are currently admitted on compulsory orders. There are potentialities for improvement, but for these to be fruitful a firm commitment will be required from the professionals involved to attend to these patients' needs. The tide generated by the new legislation is more likely, however, to carry the professionals away from these patients for the main thrust of the new Act is to make treatment more difficult.

The starting point for this discussion is a study conducted in the London Borough of Camden between 1976 and 1978 which highlighted the most important features of patients admitted compulsorily and some of the main determinants of their admissions (Szmukler *et al*, 1981; Szmukler, 1981). It is not clear how far the findings from this study can be generalized to other areas of the country, but a case was made which suggested that Camden was not atypical of central urban areas.

The most significant findings of this study were as follows. The majority of patients admitted on an order were notably bereft of social supports and suffered from a chronic mental illness, usually schizophrenia. In the course of their long psychiatric histories they had many previous admissions to hospital, many of these on an order. Despite this, their admissions were usually short and resulted in only modest and short-lived improvements. Within a year of their index admission, 45 per cent were readmitted at least once. Follow-up services were poorly utilized by the majority of these patients, so that their care lacked continuity. The pattern of treatment was of frequent in-patient stays, with very little attention in between. The absence of follow-up care was reflected in the large proportion (36 per cent) of admissions initiated by the police; this, however, is not atypical of non-Metropolitan inner urban areas.

Arising from the results of this study were a number of suggestions as to how the number of compulsory admissions might be reduced. Important among these were approaches directed towards the maintenance of continuity of care. It was proposed that before this could be established for a particular patient, a longer period of in-patient care was necessary, during which a therapeutic or helping relationship could begin to be established. A longer period of in-patient treatment would also have permitted a more careful formulation of management plans, both short-term and long-term. An argument was presented for the greater appropriateness of admission under Section 25 or Section 26 than under Section 136 and Section 29, the latter often resulting in a short stay and early self-discharge. The difficulties in implementing the former were noted, particularly the frequent absence of a relative and the common fact of the patient's not being registered with a GP. Delays in obtaining the services of a social worker and an 'approved' doctor were often intolerable. The need for a properly organized emergency service was highlighted. The lack of social provisions for patients after discharge (e.g. stable accommodation) was disillusioning and militated strongly against the formation of a stable bond between the patient and the hospital.

The impact on readmission rates and on the quality of the patients' lives of a service aiming at a longer in-patient stay, directed towards establishing the basis of more satisfactory follow-up arrangement, is difficult to predict with any certainty. However, this approach was seen to be successful in a number of cases where the patients initially were not interested in help. With most patients, one was left with the uneasy feeling that despite their long psychiatric histories, they had never been the subject of an adequate course of treatment, nor had much serious attention been given to their needs for social provisions.

It is this group of patients who are most in danger of being neglected even further as a consequence of the new legislation.

Changing options

Admission of patients under a 28-day order, formerly for 'observation', now for 'assessment', will be a very different affair. The requirements for the application and medical recommendations remain substantially the same, but the nearest relative will have the power to discharge the patient, and the patient will now have the right to appeal within 14 days to a Mental Health Review Tribunal for the detention to be reviewed. After his admission, the patient will be informed by the hospital managers of his right to appeal. There will be legal obligation on hospital managers to do what they can to ensure that such a patient understands his legal status and his rights. The nearest relative will also be informed in writing. In addition, the patient will be entitled to legal aid and representation for his appeal.

It is difficult to predict how many of the 6,000 or so patients at present admitted annually under Section 25 in England will elect to appeal. A reasonable guess is that most of them will, since they will be approached soon after admission with the information that they must decide on this with some urgency. If they are unhappy about their admission, which is after all why an order was necessary, then it would be surprising if they were to decide not to

appeal. The nearest relative, where there is one accessible, will also be subject to considerable pressures from some patients to order their release.

If Mental Health Review Tribunal hearings resemble those presently held, then the professionals involved will need to prepare the usual reports and attend to give evidence, both time-consuming activities. Psychiatrists will also be invited to other hearings as independent doctors, and if the demand is large, further considerable inroads on their time for clinical practice will be made. With patients being represented by solicitors, hearings will assume a stronger adversarial quality. To most doctors, this is inimical to their concept of the doctor-patient relationship.

In these circumstances, it would not be surprising if there were a significant decline in the use of 28-day orders. The effort will not seem worthwhile for a relatively short period of treatment, which will in any case be interrupted by the appeal proceedings, which in turn will interfere with the establishment of a good relationship with the patient.

Doctors will then face a number of other alternatives. The first would be not to admit the patient at all. Reasons can often be found for not admitting a patient. Doubts can be raised as to whether the patient is indeed suffering from a mental disorder, or if he is, whether he presents a danger or whether treatment will make any difference to his state. The second alternative would be to admit the patient under a three-day emergency order. This might prove the most attractive option if the patient is obviously suffering from a mental illness and the need for admission is imperative. (The situation might be similar to that obtaining in Scotland at present, where well over 90 per cent of compulsory admissions are under Section 31, which limits detention to seven days but does not require a Sheriff's approval, with only a small percentage under Section 24, which does require a Sheriff's approval.) After admission, the patient might elect to stay as an informal patient or if he has shown some small improvement after three days, as often occurs, he might be allowed to take his own discharge.

The third alternative would be to admit the patient directly under a Treatment order, or to admit the patient under a three-day emergency order with a view to implementing a Treatment order later. The demands placed on the professionals involved will be similar for a Treatment order and a 28-day Assessment order. In both instances the nearest relative has the right to discharge the patient, and the patient may appeal to a Mental Health Review Tribunal. However, in the case of a Treatment order there is more time (up to six months) to engage the patient in treatment and to make comprehensive management plans. If one were committed to providing adequate treatment, particularly for a patient where a previous short admission has resulted in little change, then this would be the order to go for. From the point of view of the professionals involved, the amount of work required in implementing this order will not be significantly greater than for a 28-day order.

Thus it appears that the new legislation will tend to make less attractive a middle course involving limited treatment, with patients either being offered virtually no treatment on the one hand, or the possibility of serious treatment on the other. It is here that the professionals will find their commitment to the chronic, psychotic patient severely tested. The easiest options to take will be those of not admitting the patient or of using a three-day order to stem a crisis.

There will be some further obstacles to the employment of a treatment order. A term of up to six months' detention may seem a long time to some relatives, especially when set against the possibility of a 28-day order instead. They may insist on the latter. In addition there will be some new requirements regarding the treatment of detained patients and the question of their consent. In the Camden study, the basis of treatment was in the vast majority of cases, nursing care and medication, usually of the phenothiazine group. Under the Amendment Act the prescription of medication to patients who do not give consent or who are unable to give consent will be restricted. It appears that for the commonly used drugs, administration without the patient's consent will be possible for up to three months on the authority of the responsible medical officer. After three months, if the patient is still not consenting or unable to consent, then a second, independent medical opinion will be necessary from a doctor under the authority of the newly constituted Mental Health Act Commission for drug treatment to be able to be continued. It is difficult at this stage to know how often such a situation will arise, since in the Camden study few compulsory patients received medication for anywhere near three months. The stipulation requiring an independent opinion at this stage is not unreasonable, but it introduces a potential for serious confusion concerning clinical responsibility for the patient when the independent doctor dissents from the view of the responsible medical officer that further treatment is justified. The dissenting view will be the one which will prevail. If the responsible medical officer is unable to administer the treatment which he believes necessary, and at the same time considers the patient to be a serious risk to himself or others, he will find himself in a quandary. Will there be any point in keeping the patient in hospital any longer? If the patient is discharged by the responsible medical officer, who will be seen as bearing the clinical responsibility for the decision? If the patient were then to come to grief, from whom would the patient or relatives later be able to seek redress?

Other treatments to be specified in the regulations and which will include ECT will not be able to be administered to a non-consenting patient without a concurring independent medical opinion, while other treatments still, which will include psychosurgery will require both the patient's consent and assent from an independent doctor.

The creation of a special health authority—the Mental Health Act Commission—to protect the interests of detained mental patients, to review the use of powers of detention and

to produce Codes of Practice on admissions procedures and treatment of detained patients is to be welcomed in principle. It is likely that this Commission will exert a considerable influence on the manner in which the law is interpreted and on professional attitudes to criteria for admission and treatment. It is to be hoped that the use of compulsory powers will be monitored effectively and that patients' rights to treatment will receive as much consideration as their rights to liberty. Detailed statements concerning cases reviewed and decisions taken by the Mental Health Act Commission should be made available. In view of the greater role to be played by Mental Health Review Tribunals, it is also to be hoped that the reasons for their decisions will be expounded in more detail than at present. The College could make an important contribution by monitoring the activities of both bodies. A research unit under its aegis could provide valuable information on the impact of these decisions, particularly those against detention or treatment, on patients' subsequent histories.

Conclusions

If the discussion above is accurate with regard to the implications of the new 28-day Assessment order, then psychiatrists and social workers will find themselves forced to reveal more clearly their fundamental attitudes to a difficult group of patients with chronic mental illnesses. Choices will be more polarized. They will have to decide between offering virtually no treatment or of committing themselves to an attempt at serious treatment. These patients often appear as potentially unrewarding to treat, since the likelihood of a cure is remote. It is possible, however, that with good management the quality of their lives may be considerably improved and their suffering reduced. To achieve these goals, which to many will appear modest, much energy will need to be expended. Will this be thought worthwhile? If the easy alternatives are taken, this will mark yet another step in the progressive neglect of a section of the chronically mentally ill who are encompassed so poorly within the movement to keep psychiatric patients within the community. It is possible to envisage that such patients will eventually be no longer 'labelled' as mentally ill, but instead regarded as 'eccentrics' or as suffering from 'personality disorders', and thus unsuitable for treatment. Some will find themselves in the courts, through which, with the new powers for remand and interim hospital orders, a proportion will end up via a more circuitous route again in hospital.

Perhaps many in our profession will consider these trends an acceptable price to pay in a society which is concerned to preserve a variety of civil liberties. Others may feel that a group of ill people who have virtually no public voice require some support in gaining other rights, including that to humane and adequate treatment. The problems are worthy of serious discussion.

REFERENCES

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News Items

Mental Illness Research Liaison Group

The Mental Illness Research Liaison Group of the DHSS has produced a further appendix to its strategy statement on research in the field of the elderly mentally ill. The new appendix sets out the RLG's view on the subjects needing further investigation and is produced in order to help those researchers who might be interested in doing some work in this area. Its emergence should not be taken, however, as an indication that funding of such research is readily available—it is not. DHSS research funds, like others, are under pressure and proposals will have to compete with many others for funding. Further information and copies of the Department's standard application can be obtained from the Office of the Chief Scientist, DHSS, Alexander Fleming House, Elephant and Castle, London SE1 6BY.

A Guide to Training Resources for Staff Working with 'Confused' Elderly People

This guide gives details of books, articles and audio-visual materials which might be useful to anyone training staff or volunteers working with elderly people. It also contains a list of issues which a training programme might cover and suggests training exercises and methods.

It is hoped that the guide will encourage people to submit their own materials and methods for inclusion in future editions. The guide is available from the King's Fund Centre, 126 Albert Street, London NW1 7NF—price 50p (including post and packing). For further information on King's Fund Centre publications in the field of long-term and community care, please send an s.a.e. to the King's Fund Centre at the address above.