senior registrars, during any approval exercise for higher professional training. Where no attempt has been made to cater for those doctors who wish to train on a part-time basis, indication should be made, that the absence of such a scheme is one of the factors considered by the approval panel, when accrediting higher professional training in psychiatry.

(b) We suggest that particular consideration be given to four main areas:
   (1) the current difficulty in obtaining part-time training
   (2) the quality of training in current part-time schemes
   (3) the possibility of incorporating part-time training into normal rotational training schemes, as in the West of Scotland
   (4) the possibility of splitting posts in job rotations.

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Recommended amendments to the Mental Health Act 1983

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Having been closely involved in the admission of patients into hospital under various provisions of the Mental Health Act 1983[1,2,3] (and its predecessor, the 1959 Act), I have made notes over the years of aspects of the 1983 Act which need to be amended in the interests of the patients, their families and the professionals who have to care for them in hospital and in the community.

Part I: Application of the Act

The Act applies to mental disorder, which is defined as "mental illness, arrested or incomplete development of the mind, psychopatic disorder and any other disorder or disability of mind".

Arrested or incomplete development of mind is further subdivided into mental impairment and severe mental impairment, both of which are defined; as is, indeed, psychopathic disorder.

But no definition of mental *illness* is offered. Considering that the majority of patients who get admitted under the provisions of this Act come under the mental illness category, it seems appropriate that an attempt should at least have been made to define mental illness.

Part II: Compulsory admission to hospital, and guardianship

There was confusion over the interpretation of Section 25 of the 1959 Act, and there is confusion over *Section 2* of the 1983 Act. Doctors and social workers frequently clash over this point, whether Section 2 provides for *treatment* as well as assessment.

Of course, *Section 2* does provide for treatment, but this is stated in such a roundabout way that it does leave room for confusion.

What specifically constitutes an *assessment*? And is it the case that, if treatment is offered under this Section, it should only be given *after* the assessment has been completed?

It would help everyone concerned if *Section 2* should provide for "Admission for Assessment and/or Short-term Treatment".

This would also get around the long-running argument, whether to apply *Section 2* or *Section 3* pro-

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visions on a patient with an *established* mental illness who has suffered a relapse of his condition, and who the doctors feel may get better with short-term treatment.

Section 3 could therefore be re-worded to provide for "Admission for longer-term treatment."

Neither *Section 2* nor *Section 3* makes any reference to the main reason for compulsory admission, which is that the patient who is sufficiently ill to warrant hospital treatment, *refuses*, for whatever reason, to be admitted.

Without a specific statement to the effect that the patient *has refused* admission into hospital, (or with reference to Sections 7 to 10, reception into guardianship), the basis of compulsory orders does not exist.

The patient may be "suffering from mental disorder of a nature or degree" which warrants his detention in hospital, and it may be all too obvious that "he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons", and yet agree – or sometimes even ask – to be taken into hospital.

The application of *Section 5 (2)* has also given cause for confusion. It should be made very clear that *any* patient in *any* part of *any* hospital, be it a psychiatric hospital or a general hospital, and whether the patient is receiving psychiatric treatment or not, may be liable to detention under *Section 5 (2)* if the doctor in charge of his treatment believes that a mental disorder of sufficient degree has become evident.

It should also be made clear that the registered medical practitioner in charge of the treatment of the patient at the time, be he a surgeon, gynaecologist, physician or psychiatrist, may furnish a report to the hospital managers to that effect.

Section 5 (3) should therefore specify that the registered medical practitioner and his nominated deputy need not necessarily be psychiatrists. Where a non-psychiatric consultant and/or his deputy furnishes a report under Section 5 (2), a psychiatrist should be involved as soon as possible.

Whereas Section 6 (1) specifies the authority of the applicant, or any person authorised by him, "to *take* the patient and convey him to the hospital", *Section 8* is not that specific about guardianship. The application for guardianship confers on the local social services authority, or the patient's guardian, the power to *require* the patient to reside at a specified place and to attend specified places for medical treatment and other activities.

But the power to *remove* the patient under a guardianship order, to the specified place of residence, is not granted.

The social services and the guardians should be given specific legal leverage in this respect, so that if the patient refuses to do what is required of him, it does not become a matter of argument between the authority or guardian and the patient.

Section 12 (2) provides for the approval of doctors by the Secretary of State "as having special experience in the diagnosis and treatment of mental disorder". However, in practice, it is not so much the diagnosis and treatment of mental disorder that the Approved Doctor in called to deal with, but to take a decision about compulsory admission. No reference, however, is made under this Section to the Approved Doctor having achieved any familiarity with the provisions of the Mental Health Act.

I would therefore suggest that *Section 12 (2)* should provide for the approval of doctors "as having special experience in the diagnosis and treatment of mental disorder, *and* in the correct interpretation of the Mental Health Act 1983". The approval of doctors should therefore include the demonstration that they have studied and that they understand, the Act.

Section 13 (4) has been the source of considerable unhappiness to doctors and Approved Social Workers alike, "If in any such case that approved social worker decides not to make an application", it states, "he shall inform the nearest relatives of his reasons in writing".

This is a really huge hiatus in the Act. For, when the ASW has informed the nearest relative of his reasons (in writing), and presumably the doctors (over the telephone), the responsibility for the care of the patient is left very much in the air. The ASW, if he is conscientious, may suggest alternatives to admission, or offer to return and review the case.

The hospital consultant cannot do anything for the patient, because he is not yet under his care. The GP cannot stay with the patient 24 hours a day, and it takes time to arrange visits by community psychiatric nurses.

In the interval between the refused application for admission, and eventual action, anything could happen. The patient, for example, could harm himself or other people.

It needs to be clarified who is reponsible for the patient in this circumstance.

Section 20 (3) provides for the review of a detained patient during the period of "*two months* ending on the day on which a patient . . . would cease under this Section to be so liable . . ." The practical effect of this is that RMOs tend to be sent renewal requests two months in advance of the end of the period of detention; and tend to forget about this until the last week of detention, or thereabouts.

Perhaps it would be more practical if the request for re-examination would be sent during the last two weeks of the patient's detention, to enable a truly up-to-the-minute re-assessment.

Part IV: Consent to treatment

Section 56 (1) (b) excludes patients detained by

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virtue of Sections 5 (2), 5 (4), 35, 135, 136 and 37 (4) from the consent to treatment provisions.

Thus, these patients enjoy the same status as informal patients, and treatment may be imposed on them only under Common Law. This is illogical. A patient is only detained under *Section 5 (2)* if there has been a deleterious change in his mental state. Admission under *Section 136* is generally precipitated by grossly abnormal behaviour in a place to which the public has access. It is clear that patients detained under short-term orders are generally very disturbed, and may require that treatment be given in order to contain their behaviour.

Specific provision should have been made for this, instead of leaving a situation in which such a patient might feel he has been unlawfully treated against his will.

Section 63 could have done with a positive statement such as: "With the exception of treatments falling within Section 57 or 58 above, any medical treatment may be given to a patient detained under the provisions of this Act, without his consent."

Part V: Mental Health Review Tribunals

The option of appealing to Hospital Managers as well as Mental Health Review Tribunals is obviously an important safety net for patients detained under the Act, and also helps those involved in making the recommendations and application for detention to keep the patients regularly under review.

It also has its problems.

Section 66 (2) (a)–(g) provides for patients to appeal to a Mental Health Review Tribunal within varying periods "... beginning with the day" on which the patient was admitted, the application accepted, and so on.

Many patients take this exactly as it is stated, and appeal against their detention *immediately* on admission, and they frequently appeal to both the Hospital Managers and the Mental Health Review Tribunal.

Considering that the admission would have been the result of two (independent) medical recommendations and an (also independent) application, it hardly makes sense for the RMO immediately to have to re-justify the admission. Thus the first few days of the admission sees the RMO preparing *reports*, instead of getting on with the business of a clear-headed assessment of the patient.

I would suggest that:

(a) A patient detained under Section 2 provisions may appeal only after the expiry of seven days, to allow the hospital team time to make a proper assessment.

(b) A patient detained under Section 3 may appeal only after the expiry of 14 days.

(c) In the case of Section 2 patients, they may appeal either to the Hospital Managers or the MHRT, and not to both.

(d) In the case of Section 3 patients who are allowed *one* appeal to the MHRT during each period of detention, there should also be a limit to the number of times they may appeal to the Hospital Managers.

While Section 23 (2) and *23 (3)* establish the power of Hospital Managers to discharge detained patients, nowhere in the Act is there a set limit to the number of applications for discharge that a patient may make to the Managers; yet Section 66 (1) specifies that "an (that is *one*) application may be made to a Mental Health Review Tribunal within the relevant period".

Section 69 (1) (a) makes it clear that a patient admitted to hospital under a Hospital Order may not apply to a Mental Health Review Tribunal earlier than six months from the date of the order. However, there is no specific provision preventing such patients from appealing to the Hospital Managers.

Part X: Miscellaneous and supplementary

Section 131 provides for the informal admission of patients.

There is a multitude of views regarding the conditions of informal admission. For example, is an informal patient free to come and go (from the hospital) as he pleases? Is he free to accept or refuse medication? If he leaves the hospital, goes back to his home and refuses to return to the hospital, is there any authority to bring him back to hospital?

These, and related subjects, would probably best be covered in a Code of Practice.

Certainly, the various Sections of the Act make clear the effects of an application for admission or for guardianship. Informal admission could do with a similar clarification.

Conclusion

It is my hope that the Department of Health and Social Security, the Mental Health Act Commission and the Royal College of Psychiatrists will give consideration to these recommendations.

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