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Mental Health Review Tribunal – new decision form

DEAR SIRS

I was alarmed to see that the above forms were initially incorrectly worded as to the reasons for a patient's detention under the Mental Health Act 1983. That is, they asked the question whether the Tribunal was satisfied that, "it is not necessary for the patient to be detained for his 'health *and* safety' instead of for his 'health *or* safety' ". Since this error was pointed out, the decision forms have been correctly worded. However, I am concerned about the persistence of this fundamental mistake within the Mental Health Review Tribunal system and believe it reflects a widespread lack of clarity in the understanding and use of the Mental Health Act 1983.

I would suggest that consideration should be given to the relevant wording being changed throughout the Act to read:

> This ought to be so detained (i) in the interests of the patient's own health, or (ii) in the interests of the patient's own safety, or (iii) with a view to the protection of other persons.

I feel it is unfortunate to have such an obvious confirmation of the need for the Secretary of State for Health's investigation in relation to the MHA 1983 into whether "the present legal powers are being used sufficiently effectively".

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Charges for advocacy

DEAR SIRS

A patient admitted when manic appeals against a Section 3 detention and engages a legal representative. On the day of the tribunal, with a greatly improved mental state, he withdraws the appeal but naturally is still charged by the solicitor. The fee amounts to several hundred pounds.

In general I would counsel my patients against entering into a formal contract and incurring expenditure at this level while their judgement was impaired. Clearly in this case it would be improper to seek to dissuade a person from obtaining independent legal advice.

In April of this year eligibility for legal aid became more restrictive. Many more patients will be charged for legal advice at tribunals. Is it not time to consider an independent advocacy service, at no charge to detained patients?

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The nominated deputy

DEAR SIRS

Section 5(2) of the Mental Health Act, 1983, provides for the responsible medical officer to nominate one deputy to act on his behalf, whereas no such provision existed in the 1959 Act. However, a national survey has revealed wide differences between health districts as to who acts as the consultant's nominated deputy during the daytime, although not at night (Cooper & Harper, 1992). We suggested that the on-call junior psychiatrist is the most suitable doctor to fulfill this role, and hence determined to study whether the outcome of section 5(2) is affected by who signs the form. We wish to report out findings.

Psychiatric services are provided on three main hospital sites in Leicestershire. Junior psychiatrists receive training in the purpose and provision of section 5(2) as part of an induction course, and are obliged to discuss cases with the responsible medical officer or on-call consultant prior to implementation of the section. The records of patients detained under section 5(2) at the three sites, during the year 1991, were scrutinised. The doctor implementing each section was noted, as was his status. Outcome of section 5(2) was recorded in terms of application for admission under sections 2 or 3, or reversal to informal status.

During 1991 there were 142 detentions under section 5(2) for which the signatory of the form and outcome of the section could be elucidated. Of the 28 patients detained by the responsible medical officer, 12 were subsequently admitted under section 2 of the act, five under section 3 and 11 reverted to informal status. Of the 114 patients detained by the on-call junior psychiatrist, 45 were subsequently admitted under section 2, 17 under section 3 and 52 reverted to informal status. Hence outcome was no different whether the section was implemented by the responsible medical officer, or by the on-call senior house officer/registrar, acting as the nominee.

Section 5(2) is an emergency provision. For the majority of hospitals the doctor most readily available to deal with emergencies is the resident on-call junior psychiatrist. If the on-call senior house officer/registrar was nominee to each consultant during the daytime as well as at night, this would provide for one doctor to be nominated as deputy for each 24 hour period. Analysis of outcome of section 5(2)s in Leicestershire supports the view that the

on-call junior psychiatrist is suitable to act as nominated deputy.

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Reference

COOPER, S.-A. & HARPER, R. (1992) Section 5(2): who acts as the consultant's nominated deputy? *Psychiatric Bulletin*, **16**, 759–761.

Section 5(4)

DEAR SIRS

I was disappointed to see this title to an article in the March 1993 issue of the *Psychiatric Bulletin* as it represents a sad view of editorial policy.

All Acts of Parliament are divided into sections and sub-sections, so this title is meaningless. This is particularly true with the Mental Health Acts of the different countries of the UK, where section numbers do not necessarily coincide with respect to content.

Furthermore, the authors do not at any point in their article include a formal statement of the content of the particular section though they do outline its use. They assume that all readers are familiar with the jargon, because of course that is what it is, of the psychiatric professionals. This is also true of their reference to other sections of the Act, 5(2), 2 and 4.

Professor John Gunn wrote a letter to the *Bulletin* shortly after the implementation of the Act proposing the use of abbreviated titles for relevant sections so that their general function was apparent to all readers. This proposal has been taken up by the Examinations Sub-Committee for use in the examinations.

I suggest that a similar policy is followed by the *Bulletin* in particular, and indeed in all situations within the College where sections of the Act are discussed.

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That a description of the function of the particular function of the Act would be a much more useful and appropriate title is accepted and we will endeavour to ensure that this occurs in future. *Eds.*

Audit of in-patient antidepressant use

DEAR SIRS

Much has recently been written about the use of selective serotonin re-uptake inhibitors (SSRIs) in the treatment of depression where it seems their place has not been established (Ferrier *et al*, 1992).

To investigate local prescribing habits, a point prevalence survey of antidepressant use in in-patients was undertaken at Bootham Park Hospital in York. On the day of the census there were 96 in-patients, 41 of whom were on antidepressants. More than half of these were on SSRIs (22). Reviewing the case-notes revealed that 14 patients were on antidepressants for the first time (five on SSRIs, nine on tricyclic and related antidepressants (TCAs)). Both the patients on SSRIs and those on TCAs were treated with antidepressants alone, and in combination with lithium, neuroleptics and ECT (except sertraline). SSRIs were prescribed more often than TCAs in those patients with depression plus dementia and those with high suicide risk, as would be expected.

The commonest rationale for specific current antidepressant treatment was suicide risk (four on SRRIs, one on TCA[lofepramine]), intolerance of SSRI/TCA (2,3) and failure of SSRI/TCA (3,4). No written rationale was found in 18 of the 41 patients on antidepressants. Prescription of SSRIs varied between the seven consultants (range 0/5 patients on antidepressants to 6/6).

The results appear to reflect both the current trend towards widespread use of SSRIs and the lack of consensus about their indications. Although the rationale for particular antidepressant use is complex and includes patient, medication and physician factors, to produce a written statement explaining why a particular type of medication is used would be a useful objective for the audit cycle. Regular documentation of reasons behind the prescription of SSRIs and TCAs would be beneficial not only for individual patient management but to aid more focused future research to clarify and perhaps reach consensus regarding the physical management of depression.

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Reference

FERRIER, I. N., SILVERSTONE, T. & ECCLESTON, D. (1992) Selective serotonin re-uptake inhibitors: use in depression. *Psychiatric Bulletin*, **16**, 737–739.

Cutting costs without cutting corners: a case for sound pharmacotherapy

DEAR SIRS

Working for Patients proposed a health care system based on managed competition between care providers with treatments priced in advance. The working Group of the Royal College of Psychiatrists expressed concern about such a system. Glover