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Original articles

Disagreements between psychiatrists and social workers over compulsory admissions under the 1983 Mental Health Act

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We followed up 33 cases over three months where psychiatrists recommended the compulsory detention in hospital of mentally ill men and women but social workers disagreed. Seventeen of the cases were detained a mean of 25 days after the index date of assessment by social workers, but the group as a whole spent fewer days in hospital than a "control" set of patients whose detention had been agreed ($P=0.02$). The terms of reference of the Mental Health Act Commission should be extended to cover such cases.

No doctor likes to compel a patient to go into hospital. Regrettably, some patients with severe mental illness lack insight and refuse to enter hospital for the assessment or treatment they need. If detention contributes to the patient's health and safety or serves to protect others, doctors can recommend admission under the terms of the Mental Health Act, 1983 (MHA) provided that the conditions of the relevant Section are met. These include: under Section 2 that "he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment ... for at least a limited period"; under Section 3 that "he is suffering from mental illness ... (that) is of a nature or degree which makes it appropriate for him to received medical treatment in a hospital ... (and that such treatment) cannot be provided unless he is detained under this Section"; or that "in any case of urgent necessity, an application for admission for assessment may be made ... as an emergency application ... (that) shall cease to have effect on the expiration of a period of 72 hours ... " (Section 4).

These sections of the MHA are put into effect when an approved social worker (ASW), or nearest relative, completes an application for detention. Before making such an application, the social worker must pay heed to relevant details, especially the relatives' wishes. And he or she shall "interview the patient in a suitable manner and satisfy himself that detention in a hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need" (Mental Health Act, 1983).

The Act provides a number of safeguards: the application for detention by the ASW or the nearest relative must be founded upon appropriate medical recommendations; and in the case of S3 (but not S2) cannot be made by the ASW if the relative disagrees, the hospital managers have a "duty to ensure that the grounds for admitting the patient are valid and reasonable and that all relevant admission documents are in order"; and they can decide "whether a detained patient should be discharged" (Code of Practice, 1990). Provided the patient is not the subject of a restriction order (S41), the responsible medical officer may discharge the patient. In addition, the patient (or relative) can apply to leave hospital through a Mental Health Review Tribunal made up of at least three members – a chairman with legal experience, a registered medical practitioner, and a lay member approved by the Lord Chancellor.

We carried out this study of cases where social workers did not support the medical recommendations for compulsory admission in an attempt to clarify these issues. Because such differences of opinion may result in a delay in patients receiving medication, under supervision or not, we also examined a series of 150 case-notes to find out how soon newly admitted patients are given medication.

The study

The main study covered five north London hospitals (Chase Farm, Friern, Royal Free, St Ann's, and Whittington) serving six districts and lasted for 12 months. We omitted two other hospitals sharing the service to Bloomsbury, one of the six districts. Psychiatrists from the five hospitals in the study were asked to tell us when their recommendations for

patients' admission under the MHA had not been supported by ASWs. We obtained further details from the case-notes and where possible interviewed the patients, relatives, social workers, family doctors, and psychiatrists. For a comparison group, we chose the next patient from the same district to be detained compulsorily. One of us (RS) assessed each patient's progress over the next three months and rated the overall severity of illness on a global four-point scale, ranging from well to severely ill.

Paired and non-paired t-tests were used for continuous measures; χ^2 tests, with Yates' correction where appropriate, for categorical data. Means are quoted with their respective standard errors.

Separately, we reviewed the case-notes of a series of 150 admissions to a 60-bed psychiatric teaching unit to find out how quickly patients receive medication after entering hospital.

Findings

Base population

The five districts had a total population of 727,000 with a compulsory admission rate for sections 2 (n = 351), 3 (n = 172), and 4 (n = 79) of 0.0008% a year compared with the figure for England of 0.0003%.

Although we did not include cases where recommendations for section were made by family doctors only, we probably identified the majority of unsupported sections in the target population; none came from Chase Farm Hospital. We were notified of 35 such patients or "cases" where ASWs did not support doctors' recommendations for detention, but left out two cases because of a lack of baseline data.

Details of the patients and the comparison group

The 33 cases in terms of age (mean 37.7, s.e. 3.0, range 18–83 years), sex (48% male), marital status (24% married or cohabiting), and diagnoses (schizophrenia 52%, hypomania 15%, depression 9%, other psychoses 15%, other diagnoses 9%) were comparable to the controls; but more cases (20) than controls (12) were born in Britain ($\chi^2 = 4.91$, df 1, $P = 0.03$). The living arrangements of the cases (and of the controls) were as follows: living at home 20 (12 controls); alone 8 (11); other 5 (10). The number of times the cases (and the controls) had been admitted previously were: no previous admission 8 cases (5 controls); 1–4 admissions 18 (15); 5–10 admissions 6 (5); 10 or more 1 admissions (8); not known 0 (1). The duration of the current illness was: 1–30 days 13 cases (12 controls); 30–100 days 7 (4); 100 days or more 8 (15); not known 5 (2).

At the material times, 28 of the 33 cases were in hospital: 24 in psychiatric and four in general wards (16 of the 33 controls were in hospital on the index date). The psychiatrists recommended detention of the 33 cases under the following sections: S.2 (n = 20), S.3 (n = 11), S.4 (n = 2).

Social workers' reasons for rejecting detention

There was a general lack of information about how much consultation had taken place between the social workers and the doctors. The ASWs gave the following reasons for not supporting the medical recommendations: patient not ill enough (21); agreed to informal admission (4); and other reasons (8); in two cases the relatives opposed compulsory admission under S3 (but one later agreed); one patient "lacked insight", another "did not need electroconvulsive therapy"; one with a puerperal illness was thought to be better off at home with her child; and for three cases no reason was recorded (at the outset one of these patients had threatened the ASW with a knife, locked himself in a room, and turned the gas taps on).

Outcome

During the three months after the index date, 24 of the 33 cases received in-patient care informally for a mean of 22.71 days (s.e. 4.20, range 1–91). The number of patients and the sections that had been recommended, but not supported, were as follows: 15 (S2), 8 (S3), and one patient (S.4).

During the same period, 17 of the 33 cases where the ASW had rejected legal action were detained after a mean delay of 27.82 days (s.e. 6.80) for a mean of 36.47 days (s.e. 6.96). The reasons included a worsening of schizophrenic illness (12), or of the affective disorder (4), or because of a drug psychosis (1). Some of these patients were still subject to detention orders at the time of follow-up data collection.

Of the 21 patients deemed to be insufficiently ill, 11 were detained within the three months. One of these took an overdose of drugs and needed emergency resuscitation; another was detained nine days later when he set fire to his flat; one other patient, whose ASW had been "too busy to discuss his future", could not be traced.

Of the four patients who agreed to informal care, three discharged themselves without their doctor's agreement – one went abroad, one could not be traced, and one was still unwell three months later.

The patient who was not compulsorily admitted because he "lacked insight" remained severely ill, deluded, and homeless at three months; the husband of the patient who "did not need electroconvulsive therapy" made the S3 application and she recovered after treatment; and the patient with the puerperal illness, thought to be better off at home, did well out of hospital. All three patients for whom no reason for failing to complete the section was given, were later detained.

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The range of behaviour exhibited by the cases (and the controls) during the three month follow-up period was as follows: deliberate self-harm 3 cases (2 controls); harm to others 7 (6); damage to property 6 (6); other disturbance 6 (14); marital disturbance 6 (4); sexually disinhibited 7 (3). Altogether, 16 cases and 3 controls (after the expiration of S2) left hospital prematurely ($\chi^2 = 10.64$, d.f. 1, $P = 0.001$). Of these, 14 cases and 1 control were readmitted ($\chi^2 = 12.42$, d.f. 1, $P = 0.0004$). Eleven cases and 17 control received parenteral drugs, three cases and two control ECT, and three cases no medication at all.

At the end of the three months, three cases (men) were sleeping rough, and four cases could not be traced. Although not reaching significance, the cases tended to be more violent (chiefly the men), sexually disinhibited on the ward, and to have marital difficulties during the follow-up period. The controls were more overactive. On the overall rating, the cases tended to be more ill than the controls at three months (well: 11 cases [11 controls]; slightly ill: 5 [11]; moderately ill: 7 [9]; severely ill: 6 [2]; not known: 4 [0]).

Calculated from the index date of assessment by social workers, the 33 cases spent less total time (35.30 days, s.e. 5.00) compulsorily and informally in hospital during the three months than did the 33 controls (50.97 days, s.e. 4.71). The difference was significant ($t = 2.33$, d.f. 64, $P = 0.02$).

Study of 150 admissions to a psychiatric unit

In the study of 150 consecutive formal and informal admissions to a teaching hospital, 69% of the 39 schizophrenic and 62% of the 65 affectively ill patients received phenothiazine or antidepressant medication within 24 hours of admission. The schizophrenic patients as a group spent 1.1 days (s.e. 0.38) in hospital before receiving medication.

Comments

Doctors judged that 33 patients needed detention in hospital. This study shows the ostensible reasons for the social workers' disagreement, what happened to the patients, and how their fate diverged from that of a comparison group.

At the outset, these patients seemed less obviously ill than the comparison group, but since we did not assess the patients clinically ourselves we cannot give an independent view. The cases spent appreciably less time in hospital than the comparison group, 52% of the cases were detained within the three month follow-up period, a further three were sleeping rough, and four could not be traced. None of these outcomes applied to the controls. Yet at the end of three months there was no significant overall difference between the two groups in terms of mental well-being. We do not know how to explain that finding. The numbers were small; the ratings few and approximate; and the hospital milieu perhaps adverse as well as restorative.

A surprisingly high proportion of the cases were already in hospital, compared with a smaller proportion of the controls. But this may be explained by the fact that the detention of hospital in-patients is usually initiated by psychiatrists, while the detention of out-patients is more often initiated by social workers.

Social workers said that 21 patients were not ill enough to be detained. Yet illnesses cannot be graded precisely; and a moderately ill patient may need detention, while a severely ill one may not. The Act, which allows action in the interests of the patient's health, defines neither the degree of disorder nor the stages of seriousness. It would have been helpful to have had more detailed information. For six cases social workers gave manifestly valid reasons: the relatives objected, or the patients agreed to informal hospital care. But they gave no grounds in three cases; and for the patient who lacked insight and the one who needed ECT the refusal to act appeared questionable. A suitably designed prospective study might further elucidate social workers' reasons for not supporting action under the Act and, equally important, doctors' grounds for recommending it.

The cases may have been put at risk in a number of respects, but in particular from self-injury or self-neglect. In terms of self-injury, although no patient died, one took a serious drug overdose and another set fire to his flat. Our case-note survey revealed that most schizophrenic patients are prescribed drugs within 24 hours of admission. A delay in a patient's detention may mean a delay in receiving medication, and may presage a worse long-term outcome (Crow *et al*, 1986). Similarly, the 16 cases who left hospital prematurely because they were not detained may have stopped their medicines too soon.

The five districts in this study had a compulsory admission rate that was higher than the national rate. We prefer, therefore, not to project these mainly inner city figures to England as a whole. Fisher and his colleagues (1987) in a major study of the MHA, 1983 amassed 12,385 requests relating to 9,589 patients from 42 local authorities. Of the requests for compulsory admission: 72% of the patients were detained (in contrast to our 95%), 13% diverted to informal hospital care, and 15% to community options. No data were provided, however, to show what happened to the diverted patients in the next few weeks. Yet, as this study shows, follow-up details are vital.

One reason for disagreement between social workers and psychiatrists may be the way the Act is

construed. Fisher believes that social workers are required "to assess whether the mental distress experienced by the client constitutes mental disorder in the terms of the Act and to assess appropriate action." They should take account of social and environmental factors that "may lead to pressures that are expressed in symptoms of mental distress, because this will affect the appropriateness of a response based on treatment or focussed on alleviating pressure." In our study, however, the disagreements that did occur concerned the severity of the illness rather than the diagnosis.

Even so, social workers do have to judge for themselves, not act at the behest of doctors. "It is the business of the duly authorised officer (ASW), rather than that of the doctor, to see that statutory powers are not used for the purpose [of hospital treatment] unless the circumstances warrant it" (Buxton v. Jayne, 1960). These include medical opinion; the relative's views; the patient's wishes, social and family details, culture and history. But problems may arise if these factors are weighted inappropriately. For example if, with the relative's consent, the psychiatrists propose S3 because, among other reasons, the patient refuses to take the medication he or she needs (which might also involve S58), there may be no option but to admit.

Differences in the models of mental illness that the professions adopt may explain some of these difficulties (Bean, 1980). When Fisher and his colleagues refer to "alleviating (social and environmental) pressure", for example, they seem to be implying that a patient can be restored to health by dealing with the last link in a causal chain – a current mental stress whether good or bad. By contrast, the medical model is complex. Aetiology includes remote, intermediate, recent, and maintaining events as well as physical, mental, and social factors. Mental stress may provoke an acute psychosis that for a while becomes autonomous, beyond purely psychotherapeutic or social aid (Campbell, 1983). Cases like these need urgent medical treatment – drugs can curtail a psychosis so that patients regain their normal judgement more quickly and can then take their own decisions.

We propose three measures. When any one of the parties to a compulsory admission (nearest relative, ASW, or doctor) dissents and as a result thwarts the admission, he or she should be required to give the reasons for the dissent. Despite views to the contrary (Jones, 1988), we think that when doctors and social workers disagree, social work departments should be asked to provide a second opinion – as is effectively the case for doctors when they act under S2 or S3. In the longer term, hospitals and social services departments should be required to keep a statutory register of instances of disagreement; and the MHA Commission, whose duties at present are confined to detained patients, should have its terms of reference extended so that it can monitor such registers and make recommendations.

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References

BEAN, P. (1980) *Compulsory Admissions to Mental Hospitals*, p. 167. Chichester: John Wiley.

Buxton v. Jayne. (1960) *The Weekly Law Reports*, 1, p. 794. Court of Appeal.

CAMPBELL, P. G. (1983) Psychogenesis. In *Handbook of Psychiatry 4: The neuroses and personality disorders* (eds. G. F. M. Russell & L. A. Hersov). P. 19. Cambridge University Press.

CROW, T. J., MACMILLAN, J. F., JOHNSON, A. L. & JOHNSTONE, E. C. (1986) A randomised controlled trial of prophylactic neuroleptic treatment. *British Journal of Psychiatry*, **148**, 120–127.

FISHER, M., BARNES, M. & BOWL, R. (1987) Monitoring the Mental Health Act 1983: implications for policy and practice. *Research, Policy and Planning*, **5**, 1–8.

JONES, R. M. (1988) *Mental Health Act Manual*, p. 41. London: Sweet & Maxwell.