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Use of Section 5(2) in clinical practice

CHRISTINA POURGOURIDES, Senior House Officer; V. P. PRASHER, Registrar; and FEMI OYEBODE, Consultant Psychiatrist, John Conolly Hospital, Birmingham B45 9BD

The Mental Health Act (1983) came into being eight years ago but few studies into its use have been reported (West, 1987; Sackett, 1987). The Act provided for the setting up of the Mental Health Act Commission to safeguard the interests of detained patients and to monitor the use of the Act. The Commission visits ordinary psychiatric hospitals on an annual basis and writes a report of the visit. The Commission also submits a Biennial Report to Parliament. These reports address important issues but do not provide detailed information on the use of the various sections of the Act in differing hospitals.

There is a need to have some understanding of the pattern of use of the Act within particular hospitals and it is also desirable to have some notion of the relative use of the Act between hospitals. The use of the Act can legitimately be the focus of medical audit (Garden *et al*, 1989). Indeed, there has been a recent report of an audit of the use of Section 5(2) in a psychiatric unit in Mid-Glamorgan (Joyce *et al*, 1991).

The aim of our study was to examine the use of Section 5(2) of the Act within a particular hospital. Section 5(2) is an order which empowers the emergency detention of a patient who is already in hospital as a voluntary patient, but who wishes to leave. If a doctor believes that an application should be made for compulsory admission under the Act, all that is required is a single medical recommendation by the doctor in charge of the patient's care or by another doctor working in the same hospital and nominated by the doctor in charge. It is usual to consider a change to Section 2 or 3 as soon as possible. The patient may be detained in hospital for a period of 72 hours from the time a report is furnished to the managers (HMSO, 1990).

The study

The study was carried out in a psychiatric hospital serving a population of about 100,000 including adult and psychogeriatric patients. The demographic characteristics of the population base may have varied somewhat in the period studied due to changes in boundaries and catchment areas served. Data on all compulsory admissions and treatments from January 1984–December 1990 inclusive were available in the Medical Records Department. The original section papers of patients detained under Section 5(2) were scrutinised and the following information was gathered: times of day, day of week and month when the Section was implemented; grade of doctor making the recommendation for detention; reasons given for detention; outcome of the Section; number of consecutive Section 5(2)s; transfers to other hospitals under Section 5(2).

Findings

There were 2,614 in-patients during the study period of whom 784 (30%) were detained under the Act. There were 189 (7.2%) detentions under Section 5(2); this constituted 24% of all detained patients. This was composed of 110 (58.2%) females and 79 (41.8%) males. On average, two patients were detained on Section 5(2) each month and there was no difference between implementations of Section 5(2) for any month of the year. There was no evidence of detentions under Section 5(2) being more common

on any particular day of the week. Sixty-six (45.8%) of the Section 5(2)s were implemented during working hours while 52 (36.1%) occurred out of working hours. Data were not available on 26 (18.1%). The nominated deputies, who were senior house officers or registrars, implemented 150 (79%) of the detentions and consultants implemented 39 (21%).

The reasons for detention as stated in the legal papers were of varied quality. Examples of the least informative included: "This patient is threatening to leave the ward. In my opinion she needs to stay in this hospital and receive treatment," and "She is refusing to stay in hospital because she feels too dirty. She has received community treatment and this has broken down." The most informative recommendations included information about the patient's diagnosis and the possible threat to the safety of the patient or the public and an example is: "She has a diagnosis of manic depressive illness. She is currently overactive, verbally and physically aggressive and has been throwing objects at other patients. It has been necessary to restrain her within the ward and she indicates by her actions that she wishes to leave. In her present state she and the public would be at risk."

The outcome of the Section 5(2) was analysed. Ninety (47.6%) became informal, 68 (36%) were converted to Section 2, 28 (14.8%) were converted to Section 3 and the outcome of three was unspecified. In 15 cases further detentions under Section 5(2) were implemented, but importantly, these were not consecutive applications. Four patients were transferred to other hospitals while being detained under Section 5(2). Six patients who became informal on expiry of Section 5(2) were subsequently detained under Sections 2 or 3 within five days.

Comment

There was no evidence that the use of Section 5(2) was influenced either by changes in junior medical staff in the months of February or August respectively or by the relative absence of senior medical staff out of working hours. We had anticipated a possible increase in the number of Section 5(2)s implemented in the months of February and August, based on an assumption that medical staff at these times would be unfamiliar with the hospital set-up, or possibly new to psychiatry. This was not borne out by the results. In addition, contrary to expectation, there were marginally more Sections implemented during the working day.

Thirty-nine (21%) Section 5(2)s were implemented by the Responsible Medical Officers (RMOs). RMOs would, of course, have been well able to implement Sections 2 or 3 respectively without recourse to Section 5(2) in the interim. This finding may reflect the delay involved in obtaining the required other recommendation and Approved Social Worker's (ASW) application.

There is a paucity of literature on the adequacy or otherwise of the documentation of the decision to detain a mentally ill patient. This view was expressed by Baxter *et al* (1986) who went on to suggest that the legal document should clearly state that a qualified medical practitioner is satisfied that the person to be detained has a mental illness which causes him to be a danger to himself or others, is in need of immediate treatment and the treatment is available in an approved hospital. They stressed that the presence of mental illness does not imply that immediate treatment is required. It may also be desirable to state why Section 2 or 3 is not practicable. The quality of the documentation scrutinised during this study was variable. It should be borne in mind that documentation is undertaken in less than ideal circumstances, often with aggressive patients. The suggestion made by Baxter *et al* (1986) that a form could be designed such that RMOs are compelled to address each criterion individually is worthy of further consideration.

The Second Biennial Report of the Mental Health Act Commission (HMSO, 1986) discusses what it has subsequently called the misuse of Section 5(2). The Commission expressed concern about its use as an independent power of short-term detention for 72 hours, rather than as a means to provide authority to detain while an assessment for the purposes of an application for compulsory admission may be made. They emphasise that it must appear to the RMO implementing Section 5(2) that an application under Part II for compulsory admission ought to be made. They felt that arrangements should be made for the necessary assessment by an ASW and a secondary registered medical practitioner. This was infrequently the intention indicated on Form 12 of our hospital's detained patients. They gave examples where the assessments were left until late in the 72 hours, or where the 72 hours had elapsed without an assessment taking place. In our study, there were six patients whose Sections 5(2) lapsed before Section 2 or 3 was subsequently implemented.

Almost half of our cases on Section 5(2) were allowed to become informal following the expiry of the section. This was the same pattern nationally (DoH, 1991). This again raises questions about the purpose of Section 5(2) as expressed by the Commission. It appears as if Section 5(2) still serves the function of controlling isolated incidents of disturbed behaviour in otherwise co-operative patients. It may very well be that some clinicians regard Section 5(2) as the least restrictive action in some situations.

The Commission has also expressed the view that it is unlawful to treat Section 5(2) as providing legal authority forcibly to transfer a patient from one hospital to another. Mental Health Act Commission

Circular No. 1 states: "Where circumstances indicate that an immediate transfer to more appropriate facilities is necessary for the proper care and safety of a patient detained under Section 5(2), the patient should be fully assessed without delay with a view to detention under Section 2 or 3 if compulsory admission is indicated". In our study, four patients were transferred to a specialised High Dependency Unit in another hospital managed jointly within the same district.

This study did not take account of other critical factors such as nurse staffing levels and the grades and experience of on-duty nursing staff. The decision to implement Section 5(2) is often initiated by nursing staff and is dependent as much upon the nurse's capability to calm, restrain or persuade a patient to remain in hospital as it is on the doctor's judgement on the need for detention under the Act.

This study is an example of an audit of the use of the Act and provided valuable information on the areas in which clinical practice could be improved. Other reports such as this would provide a firmer basis for our understanding of the factors associated with compulsory detentions and treatments.

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