Consultant psychiatrists' experiences and attitudes following the introduction of the Mental Health Act 2001: a national survey

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Abstract

Objective: This study explored the attitudes and experiences of consultant psychiatrists regarding the Mental Health Act 2001.

Method: A postal survey was distributed to all consultant psychiatrists (n=238) in the Republic of Ireland. All specialties were included except Child and Adolescent Psychiatry.

Results: A response rate of 70% was achieved. Care of involuntarily admitted patients has improved according to 32%, but 48% found that the care of voluntary patients has deteriorated. Sixty-nine per cent of consultant psychiatrists acknowledge that involuntarily admitted patients are being changed to voluntary early to avoid a tribunal, and 21% believe it occurs in over 40% of cases. Fourteen per cent of consultant psychiatrists have re-admitted a patient involuntarily immediately after a tribunal revoked the original Involuntary Order. Junior doctors' training by consultant psychiatrists has been reduced in 57% of placements as a result of the increased demands of the MHA 2001. Eighty-seven per cent report an increase in their on call service workload but only 23% report a sufficient increase in the number of consultants within their service. While 78% agree that patients should not be admitted involuntarily solely on the grounds that the person is suffering from a personality disorder, 58% feel that there is a risk in such patients not being involuntarily admitted in situations in which it is clinically necessary. Fifty-six per cent feel that there is a similar risk in patients with a diagnosis of substance misuse.

Conclusion: Resources required to implement the Mental Health Act 2001 have not been sufficient leading to poorer quality of service and negatively affecting NCHDs training.

Key words: Mental Health Act 2001; Consultant Psychiatrists; Involuntary Patients; Involuntary admissions; Psychiatry.

Background

The Mental Health Act 2001 (MHA 2001) was implemented on November 1, 2006 in the Republic of Ireland replacing the previous legislation, the Mental Treatment Act 1945. The Mental Health Act 2001 has introduced significant changes to the criteria, process and practice of involuntarily admitting a person affected by psychiatric illness. Under the new legislation, the patient receives legal representation, an independent psychiatric assessment and the involuntary admission is reviewed by a mental health tribunal. A person cannot be admitted involuntarily solely on the grounds that they are suffering from a personality disorder, are socially deviant or addicted to drugs or solvents.

In the 12 months from December 2006 to November 2007 there were 2,137 Involuntary orders, which consisted of 1,504 Form 6 admissions and 633 re-grading of voluntary patients. In total, 2,227 tribunals took place across the country and 262 tribunals resulted in the involuntary order being revoked.[1]

There is a move for mental health legislation and practice to comply with the European Convention for the Protection of Human Rights and Fundamental Freedom (1950) which specifies that a person detained against their will should have a judicial review.[2] In October 2005, the Mental Health (Care and Treatment) (Scotland) Act 2003 came into force and introduced a similar system of tribunals. Carswell et al (2007) revealed that 62% of consultant psychiatrists are either unsatisfied or very unsatisfied with the Act. Fifty nine per cent reported that out of hours workload had increased and 65% of respondents felt that the care of the voluntary patient had been adversely affected by the Act.[3] In a survey regarding New Zealand's Mental Health (Compulsory Assessment and Treatment) Act of 1992, only 19% of respondents felt that the current system prioritised best clinical practice over strict adherence to the law. Seventy-one per cent thought that the Act results in the inappropriate release of patients into the community.[4]

This study evaluated consultant psychiatrists' experiences and attitudes regarding the Mental Health Act 2001 in the first year of clinical implementation. The aims were to investigate consultant psychiatrists' views regarding (i) the structure and outcome of tribunals (ii) effect on the care of the patients, both voluntary and involuntary (iii) effect on NCHDs (iv) impact on workload and resources and (v) impact on specific patient groups.

Methods

Participants

The study is a nationwide questionnaire survey of all consultant adult psychiatrists. This included all specialities including general adult, liaison, psychiatry for the elderly, addiction, forensics, learning disability and rehabilitation. Child and adolescent psychiatrists were not included. An up to date list of consultant psychiatrists was obtained by

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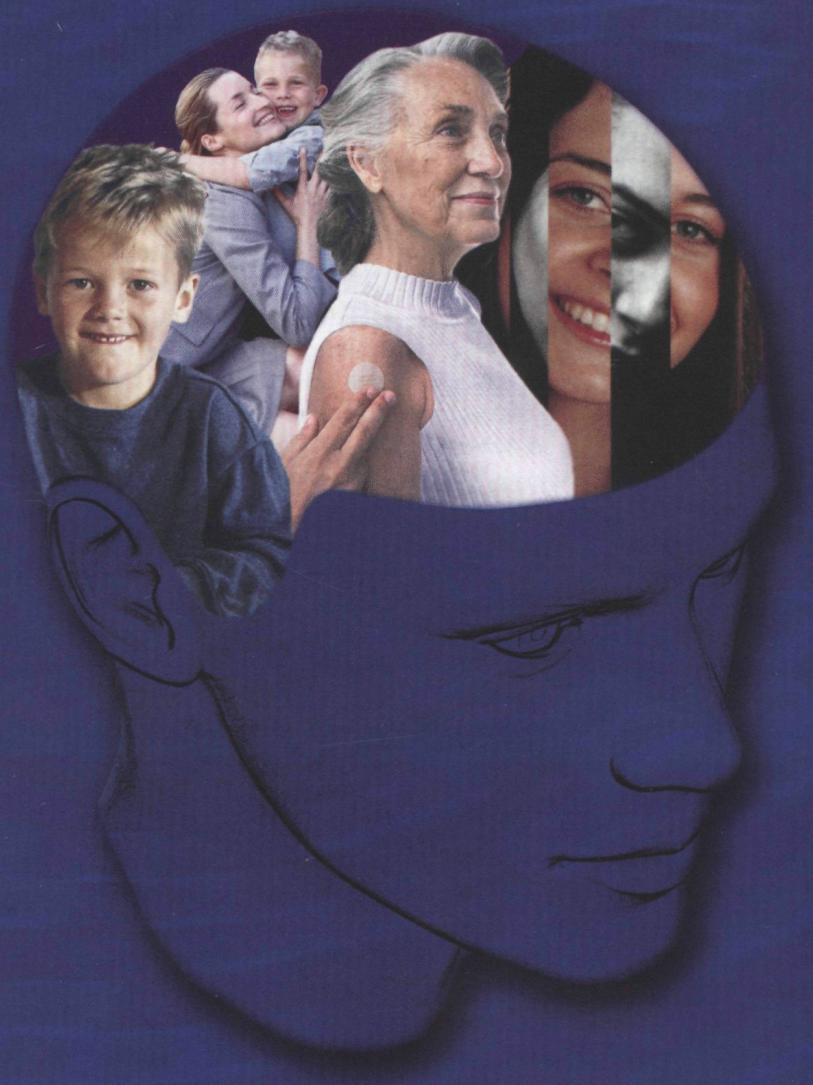

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Concomitant treatment with a reversible MAO-A inhibitor e.g. moclobemide or reversible non-selective MAO-inhibitors e.g. linezolid. Lexapro may be started 14 days after discontinuing treatment with an irreversible MAOI. At least 7 days should elapse after discontinuing Lexapro treatment, before starting a non-selective irreversible MAOI. **Pregnancy and Lactation:** Lexapro should not be used during pregnancy unless clearly necessary. Neonates should be observed if maternal use of Lexapro continues into the later stages of pregnancy, particularly the third trimester. Abrupt discontinuation should be avoided during pregnancy. Refer to the full prescribing information for a list of serotonergic or discontinuation symptoms, which may occur in the neonate after maternal SSRI/SNRI use in later stages of pregnancy. Breast-feeding is not recommended during treatment. **Precautions:** Patients should be cautioned about the risk to their ability to drive a car and operate machinery. 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Very Common: Nausea; Common: Decreased & increased appetite, anxiety, restlessness, abnormal dreams, libido decreased, female anorgasmia, insomnia, somnolence, dizziness, paraesthesia, tremor, sinusitis, yawning, diarrhoea, constipation, vomiting, dry mouth, sweating increased, arthralgia, myalgia, ejaculation disorder, impotence, fatigue, pyrexia, weight increased. **Overdosage:** Clinical data on escitalopram overdose is limited and many cases involve concomitant overdoses with other drugs. Doses between 400-800 mg of Lexapro alone have been taken without any severe symptoms. Symptoms seen in reported overdose of Lexapro mainly relate to the central nervous system, the gastrointestinal system, the cardiovascular system and electrolyte/fluid balance conditions. There is no specific antidote. Treatment is symptomatic and supportive with monitoring of cardiac and vital signs. 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contacting all psychiatric hospitals, general hospitals and mental health centres in the Republic of Ireland. A list of 238 consultant psychiatrists was obtained.

Instruments

The 21-item questionnaire, explanatory letter, prepaid envelope and an accompanying postcard was posted. It was requested that the postcard, which identified the consultant psychiatrist, be returned separately to the (non-identifying) questionnaire. Thus, complete anonymity was assured. The first ten respondents received a free psychiatric textbook to the value of €27. Unreturned postcards identified non-responders and a second round of surveys was posted to this group. The questionnaire was completely anonymous and did not contain any identifying questions.

Statistical analysis

Data were entered into SPSS version 15 for Windows. Appropriate chi-square tests were performed to determine if non-parametric data differed significantly.

Results

A response rate of 70% was achieved. Two hundred and thirty eight surveys were distributed, 166 were returned, three were returned incomplete.

Patient care

Seventy-three per cent (n=112) of consultant psychiatrists believe that the rights of patients who are admitted involuntarily are respected following the introduction of the MHA 2001 and 32% (n=51) found that their care has improved. However 48% (n=74) of consultant psychiatrists find that the care of voluntarily admitted patients has been negatively affected, 73% (n=54) of these respondents attribute this to ward rounds and clinics having to be cancelled to accommodate mental health tribunals. A small number, 8% (n=5), report that there is no provision in the MHA 2001 for the situation in which a voluntarily admitted patient is refusing treatment but is willing to stay in the hospital and there is a concern that their mental health will deteriorate or that they are a risk to themselves or others.

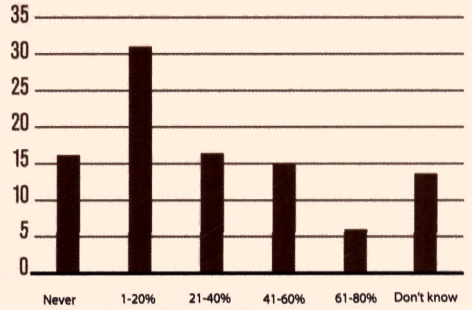
Mental Health Tribunals

The median number of tribunals attended by consultant psychiatrists is six (range 0 to 45). Fifty seven per cent (n=88) of consultant psychiatrists agree with the current system of a majority vote to form the decision of the mental health tribunal. However 25% (n=39) think that the tribunal consultant psychiatrist should have a veto in the vote while 18% (n=28) think that the decision should be made unanimously. Fifty-five per cent (n=82) of consultant psychiatrists believe that it is in the best interests of the patient to attend the tribunal. Eight-eight per cent (n=138) of consultant psychiatrists believe that tribunals should be held responsible for any consequences of their decisions and 78% (n=119) think that the tribunal process is transparent.

Thirty-two per cent (n=48) of consultant psychiatrists estimate that up to 20% of Involuntary Admission Orders are revoked early so that the mental health tribunal is avoided. Twenty-one per cent (n=32) estimate that this practice happens in over 40% of involuntary admission orders, while 17% (n=25) believe that this practice never occurs. Explanations provided by consultant psychiatrists for this practice are presented in *Table 1*.

Fourteen per cent (n=23) of consultant psychiatrists report having re-admitted a patient involuntarily immediately after a tribunal revoked the original Involuntary Admission Order. Forty-eight per cent (n=11) of these respondents report that the Involuntary Admission Order was revoked on technicalities and they had sufficient concerns for the patient mental health to commence another Involuntary Admission Order, while 17% (n=4) report that they disagreed with the findings of the mental health tribunal and the patient was unwilling to stay in hospital.

Figure 1: Percentage of time involuntary orders may be revoked early to avoid tribunals



Effects on training for non-consultant hospital doctors (NCHD)

Fifty-seven per cent (n= 89) of respondents find that training for junior doctors is reduced as a result of the increased demands on consultant psychiatrists. Eighty-one per cent (n=129) believe that senior registrars should be able to attend mental health tribunals as well as consultant psychiatrists while 23% (n=37) think that registrars (pre MRCPsych) should be able to attend mental health tribunals. Seventeen per cent (n= 26) of consultant psychiatrists have had a senior registrar "act up" for them in a mental health tribunal and 62% (n=15) report no implications or problems with this practice.

Impact on workload

Eighty-seven per cent (n=138) of consultant psychiatrists report an increase in their on call service workload following the introduction of the MHA 2001 and only 23% (n=36) report that a sufficient increase in the number of consultant psychiatrists within their service was provided. Consultant psychiatrists in services which they perceived to have received a sufficient increase in consultant numbers reported lower levels of a negative impact upon training for junior doctors (25% vs 57%). This difference is statistically significant. [$x^2(1,N=152)=15.9$, p=.00]. There was no difference in opinion of consultant psychiatrists on whether the care of the voluntarily [$x^2(1,N=156)=1.9$, p=.159] or involuntarily admitted patients [$x^2(1,N=150)=.48$, p=.49] differed between services which were perceived to have received a sufficient increase in consultant numbers than from the services which did not.

Implications for specific patient groups

Prior to the MHA 2001, 16% (n=24) of consultant psychiatrists admitted patients involuntarily solely on the grounds that they were suffering from a personality disorder and 21% (n=33) admitted patients involuntarily solely on the grounds of substance misuse. In the MHA 2001, it specifies that a person cannot be admitted involuntarily solely on the grounds that they are suffering from a personality disorder or are addicted to drugs or intoxicants. Seventy-eight per cent (n=125) of respondents agreed with this stipulation. However

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Table 1: Reasons provided why involuntary orders may be revoked early

	n	%
1. Patient has improved and does not fulfil criteria	35	23
2. To save time due to the quantity of work involved for a tribunal	27	18
3. To preserve the therapeutic relationships with patient	14	9
4. To avoid/prevent a stressful experience for the patient	11	7
5. Anxiety/stressful experience for consultant psychiatrist	10	7
6. Tribunals are adversarial/about the law and not best clinical practice	7	5
7. Psychiatrists suspects the order will be revoked anyway and it may be perceived that if revoked the original order was wrong or unlawful	5	3
8. Lack of training for psychiatrists for tribunals	4	3

58% (n=90) felt that there was a risk that patients with a diagnosis of a personality disorder may not be admitted involuntarily to hospital in a situation in which it is necessary, as a result of this stipulation. Fifty-six per cent (n=87) feel that there is a similar risk to people with a diagnosis of substance misuse.

Discussion

This study has demonstrated that the introduction of the MHA 2001 has had a significant impact on the care of both voluntarily and involuntarily admitted patients. Junior doctors' training has been compromised in over half of placements due to the increased demands on consultant psychiatrists. Consultant psychiatrists acknowledge that the practice of revoking involuntary admission orders early to avoid mental health tribunals exists and they also acknowledge incidences of overruling the decision made by the tribunal to revoke the order by commencing another involuntary admission order immediately.

Strengths and limitations

This study carries with it the limitations associated with a survey including participation bias; however the authors feel that a response rate of 70% should minimise this bias. Another limitation is that this survey only reflects the experiences and attitudes of consultant psychiatrists. For example, it was outside the scope of this study to determine the rates of cancelled clinics or ward rounds in services throughout the Republic of Ireland. However this also introduces a strength to the study, in that it has provided revelations that cannot be determined by statistics or factual sources, for example, the practice and explanations for revoking involuntary admission orders early to avoid tribunals.

Also, we sought consultant psychiatrists' opinions on whether increases in consultant numbers were sufficient for the increase in workload. This study did not set out to determine if increases in consultant numbers occurred but rather, if consultant psychiatrists viewed the increase as being sufficient. Another limitation to the study is that a breakdown of opinions and experiences of consultant psychiatrists by speciality was not performed. For example, liaison psychiatrists or psychiatrists within the addiction or forensic services may have different experiences to general adult psychiatrists. However, due to the small number of consultant psychiatrists in the Republic of Ireland per speciality, it would have been difficult to preserve anonymity; therefore it was not included in the survey.

Patient care

This study has demonstrated that consultant psychiatrists are concerned that the care of voluntarily admitted patients has been negatively affected due to the increased demands as a result of the mental health tribunals. This is a resource issue that was well recognised prior to the introduction of the MHA 2001. Dr Owens, on behalf of the Mental Health Commission, wrote "There is certainly a need for substantial investment in mental health services but current deficiencies should not be allowed to delay the implementation of legislation which gives essential protection to human rights and freedom."[5] The counter argument to this is that before change can be successfully introduced, the resources must be provided first.

Mental Health Tribunals

In this anonymous study, 23 consultant psychiatrists admitted to detaining a patient involuntarily immediately after a tribunal revoked the original order, which represents at least 9% of the cases in which involuntary admission orders being revoked by a tribunal. The main explanation given for this practice is that orders were revoked on technicalities. The consultant psychiatrists are acting, in what they judge, is in the best interests of the patient and they are overruling the decision of the tribunal. One rationale for this action is that consultant psychiatrists bear ultimate responsibly for the care of the patient and the tribunal does not have any legal responsibility if an adverse outcome occurs. This study has highlighted the wide variation in practice of revoking involuntary orders early so as to avoid a tribunal. The percentage of consultant psychiatrists who believe that this practice never occurs is equal to the percentage of consultant psychiatrists who believes it takes place 40-60% of the time. This is a startling finding and the authors hypothesis that this may be due to a variation in practice across the Republic of Ireland or it may be that consultant psychiatrists do not have a clear picture of the clinical practice of their peers.

In a mental health tribunal the decision is reached by a majority vote. However a situation may arise in which three consultant psychiatrists (treating consultant psychiatrist, independent second opinion consultant psychiatrist and the tribunal consultant psychiatrist) agree that a patient should be involuntary admitted but then the order can be revoked on

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the vote of the solicitor/ barrister and lay person. However despite this, two thirds of respondents agreed that a decision should be based on a majority vote therefore indicating that consultant psychiatrists are in favour of the transition away from the "paternal" practice of medicine.

Workload and resources

The insufficient increase in numbers of consultant psychiatrists can be explained somewhat by the ongoing consultant contract negotiations with the government; however the consultant is only one member of the multidisciplinary team. In a study of newly appointed consultant psychiatrists in the Republic of Ireland, at 12 months, 40% were lacking either an NCHD, community mental health nurse, clerical worker or an office. Only 18% of consultant psychiatrists were able to access a social worker, a psychologist or occupational therapist after 12 months. The study showed that there was a strong sense of frustration and disillusionment experienced by consultant psychiatrists early in their careers, and this was prior to the introduction of the MHA 2001.[6] With an increase in workload this may lead to a stronger sense of frustration.

Increased workload and the provision of insufficient resources to complete the work have been demonstrated to be factors in causing low morale.[7] In the UK, low morale among consultant psychiatrists is widespread and has led to difficultly in recruiting and retaining consultant psychiatrists. This has a clear knock on effect for NCHDs, who have expressed that what they want are well supervised posts and mentoring from more experienced peers.[8]

Implication for specific patient groups/risk

This study also uncovers an intriguing insight into the complex area of risk and responsibility. While paradoxically, 78% of consultant psychiatrists agree with the stipulation that patients cannot be admitted involuntarily solely on the grounds that they are suffering from a personality disorder or addiction/substance misuse, over 50% acknowledge that this may lead to a risk in patients not being admitted if clinically necessary. This suggests that consultant psychiatrists, being aware of the long-term risk of patients with a diagnosis of a personality disorder and addiction, also recognise that involuntary admissions are not the solution. It may also resolve the dilemma whereby consultant psychiatrists come under pressure from relatives/ friends to admit a patient involuntarily for the above indications. However, there are cases when involuntary admission is the safest course of action and due to the stipulation the authors hypothesise that there may be higher rates of patients being admitted with ICD-10 diagnosis of psychiatric illness of an acute nature, such as "adjustment disorders" or "brief depressive episode".

Interestingly, in the UK the opposite course of action appears to be threatened. "Reforming the Mental Health Act" is a white paper containing proposed changes to the Mental Health Act 1983 and it has a definition of mental disorder which clearly includes personality disorder. It is also stipulated that the mental health tribunal could have the right not to accept the clinician's decision to discharge the patient "if there is a serious risk of harm to others", thus creating a situation in which individuals may be detained without conviction for an offence.[9] While this legislation is aimed at individuals with a "dangerous severe personality disorder", it is not obvious what prevents the wider application of this new power.[10] It is greatly feared by psychiatrists in the UK that these changes will result in acute psychiatric wards being filled by the indefinite detention of dangerous, but unconvicted people with low "treatability", or none at all.

Conclusions

The authors hope that this study has highlighted the major relevant points regarding the introduction of the Mental Health Act 2001. The authors hope that this study will be beneficial to the Health Service Executive and Mental Health Commission when the Mental Health Act 2001 undergoes review.

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Declaration of Interest: None

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Slower titration and lower maintenance doses may be appropriate. *Children and adolescents (< 18 years)*: Not recommended. *Reduced renal function:* Usual dosage. *Reduced hepatic function:* Patients with mild/moderate hepatic impairment require slower titration and a lower maintenance dose. **Re-titration**: Not required if patients have been without Serdolect® for less than a week. Otherwise the recommended titration schedule should be followed which includes taking of ECGs. **Contraindications**: Prescribing physicians should comply fully with the required safety measures. Hypersensitivity to sertindole or any of the excipients. Known uncorrected hypokalaemia or hypomagnesaemia. History of clinically significant cardiovascular disease, congestive heart failure, cardiac hypertrophy, arrhythmia, or bradycardia (<50 beats per minute). Congenital long QT syndrome (or family history of this disease), or known acquired QT interval prolongation. Severe hepatic impairment. *Drugs known to significantly prolong the QT interval*: e.g. class Ia and III antiarrhythmics, cisapride, lithium, some antipsychotics, macrolides, antihistamines and quinolone antibiotics. *Drugs known to potently inhibit hepatic cytochrome P450 3A enzymes*: e.g. 'azole' antifungal agents (systemic treatment), macrolide antibiotics, HIV protease inhibitors, calcium channel blockers and cimetidine. **Pregnancy & Lactation**: Not recommended **Driving and Operating machinery**: Avoid until individual susceptibility is known. Serdolect is not sedative. **Special precautions**: Caution may be required in patients who develop postural hypotension (monitoring), Neuroleptic malignant syndrome (drug discontinuation) and tardive dyskinesia (dose reduction or drug discontinuation). Mild/moderate hepatic dysfunction. Risk of significant electrolyte disturbances: e.g. electrolyte monitoring recommended in patients experiencing vomiting or diarrhoea, potassium depleting diuretic use. Parkinson's disease. Caution in elderly (>65 years) and those with risk factors for stroke. Known poor metabolisers of CYP2D6. History of seizures. Breast-feeding. Dopamine agonists. Caution with concomitant use of some SSRIs: e.g. fluoxetine, paroxetine (potent CYP2D6 inhibitors). Agents known to induce CYP isozymes: e.g. rifampicin, carbamazepine, phenytoin, phenobarbital. Gradual withdrawal is advisable. Caution is recommended in patients with intolerance to certain milk sugars. Clinical monitoring is advisable in diabetic patients or those with risk factors for diabetes. **Drug Interactions:** Caution required with concomitant use of drugs that prolong the QTc interval, CYP2D6 inhibitors, CYP3A inhibitors contraindicated. Concomitant use of CYP inducers may require dose adjustment. **Adverse events**: Very Common (≥1/10): Rhinitis/nasal congestion. Common (≥1/100, ≤1/10): Decreased ejaculatory volume, dizziness, dry mouth, postural hypotension, weight gain, peripheral oedema, dyspnoea, paraesthesia, and prolonged QT interval. **Overdose**: Symptoms have included somnolence, slurred speech, tachycardia, hypotension, and transient prolongation of the QTc interval. Cases of Torsade de Pointes (TdP) have been observed, often in combination with other drugs known to induce TdP. *Treatment*: There is no specific antidote to sertindole, and it is not dialysable, therefore appropriate supportive measures should be instituted. Adrenaline and dopamine should be used with caution (may worsen hypotension). Close medical supervision and monitoring should continue until patient recovers. **Legal Category**: POM. **Product Licence holder**: H. Lundbeck A/S, Ottiliavej 9, DK-2500, Copenhagen – Valby, Denmark. **PA Numbers:** 4 mg PA805/1/1; 12 mg PA805/1/3; 16 mg PA805/1/4; 20 mg PA805/1/5. Further information is available upon request from Lundbeck (Ireland) Ltd., 7 Riverwalk, Citywest Business Campus, Citywest, Dublin 24. 'Serdolect' is a trademark ™ Lundbeck Ltd. **Date of preparation:** October 2007.

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*Serdolect should only be used for patients intolerant to at least one other antipsychotic agent.

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