Editorials

IMPLICATIONS OF THE NEW MENTAL HEALTH ACT

In 1917, Wagner Jauregg of Vienna announced that malarial treatment could benefit patients suffering from dementia paralytica, just four years after Noguchi and Moore had demonstrated the presence of *Treponema pallidum* in brain substance. This was the very beginning of a new therapeutic era in psychiatry. In those days custodial care was still the accepted role of the lunatic asylum, and no one, no matter how distraught and ill, could gain admission without the ignominy of certification. It is not surprising that family doctors and relations alike held back as long as possible from taking the dread step of calling in the relieving officer and a magistrate. The stirrings of the social conscience produced in 1930 the Mental Treatment Act. This permitted voluntary patients, and the lunatic asylum became a mental hospital. The motive behind the act was excellent, but it still took a brave person to volunteer for a hospital which had virtually no treatment to offer worthy of the name. In 1933, Von Meduna revived an old remedy described in 1798 by Weickhardt. Patients were induced to have fits by means of camphor injections. This treatment, and later the more humane electro-convulsive therapy and insulin shock, completely changed the outlook for psychoses. The spirit of inertia which had permeated the institutions for a century began to disappear, and the 1959 Mental Health Act is the natural corollary of the new enthusiasm engendered by these technical advances.

The basic theme of the new Act is the integration of psychiatry into the general medical services. Until recently the tendency has been for such work to be done in the seclusion of the mental hospital far away from other branches of medicine, and cut off from the community itself. It is too much to hope for the dissolution of mental hospitals in the foreseeable future, but the act aims in the long run to abolish them as a separate branch of medicine cut off from other departments. On the one hand, general hospitals will be encouraged to have their own psychiatric wards and outpatient departments; on the other hand, the residential type of institution will tend to have far fewer beds, and will be dovetailed into the general medical system of the community. The discharge rate of today is in the region of 70 per cent of all admissions. This will be encouraged; and with a better service which fosters early diagnosis,

prompt treatment, and a rapid return of convalescents to their own homes fewer long stay patients will be created. There will be some decentralization. In the past the Ministry of Health supervised the mental hospital admissions through the Board of Control in London. This has been abolished and in its place Mental Health Review Tribunals will be created for each regional hospital area. Thus the final court of appeal will be local and not central. Duly authorized officers, now renamed district health officers or mental welfare officers, will assist in the integration of the services. As far as possible patients will be admitted to psychiatric wards informally, just as they are now admitted to medical or surgical wards. The terms voluntary or temporary will be abandoned. As before, 16 is the age at which the patient can decide for him or herself. Before that age parents or guardians have to give permission.

In the new Act all forms of psychiatric illness are considered together and are referred to collectively as mental disorders. The terms unsound mind and mental defect have been jettisoned. The same local health authority supervises the care of persons suffering from a mental illness, or arrested mental development. Four categories of mental disorder are described.

Mental Illness applies to patients suffering from anxiety, depression, schizophrenia, dementia, and the organic psychoses, or indeed any disease imposed on a normally developed mind.

Severe Subnormality includes all patients who will never be able to care for themselves because their mental development has been arrested at a very low level. Their intelligence quotient is less than 60 per cent and formerly they would have been classified as imbeciles or idiots.

Subnormality includes patients suffering from a lesser degree of arrested mental development. They are not as helpless as the previous group, but they usually need special care and training.

Psychopathic Disorder includes antisocial types of patients who show abnormal aggression in their behaviour and whose conduct is frequently irresponsible. These patients may also be mentally subnormal, but many have a normal or even high level of intelligence.

It is anticipated that 95 per cent of patients will be dealt with informally, and only a very small proportion of cases will need to undergo compulsory admission to a hospital. This procedure, when necessary, can be enforced on patients suffering from mental illness or from severe subnormality at any age. Patients in the latter two groups, that is the subnormality and psychopathic sections, over the age of 21, can only be compelled to undergo hospital treatment by court of law.

Application for compulsory admission is usually made by the next of kin. It can be made by the mental welfare officer, but the next of kin has the right to overrule the mental welfare officer. The application is made to the board of management of the appropriate hospital, and it must be accompanied by the recom-

mendations of two medical practitioners. One will be the family doctor and the other a doctor with special experience in psychiatry authorized by the local authority. In actual practice, the general practitioner will ring up the local hospital and request a domiciliary visit. If both are agreed on the course of action they can each write their own report, or both can sign one which has been mutually agreed upon. This method is likely to circumvent the apparent difficulty which could arise, because the hospital is not bound to admit the case. A hospital would hardly refuse an admission authorized by one of its own staff. Should the next of kin refuse to accept the recommendations of the doctors, he or she would thereby automatically accept responsibility for the conduct and welfare of the patient. This is no new problem. If the family is allowed " to stew in its own juice " for a few weeks, it usually gladly comes to accept any offer of help.

The grounds for compulsory admission are two-fold: the patient must be suffering from a mental disorder, and he must be detained in his own interest because he is a danger to himself or to other people.

The doctors who complete the recommendation can do so in two different ways. An application for observation requires a statement to the effect that the patient is suffering from *a mental illness*, together with full clinical details, and the patient can then only be detained for a maximum of 28 days. If on the other hand the application is for treatment, *the type of mental illness must be described in detail*, as well as full case notes and then the patient can be detained for a maximum of a year. There is no place and no reason to describe the patient either as insane, or suffering from an unsound mind as in the old forms. The prescribed forms must be completed not more than seven days before the actual admission. In an emergency a patient can be admitted to hospital for a maximum of 3 days on the recommendation of one medical certificate, in which the doctor would have to state in detail once again that the patient was mentally ill, and a danger either to himself or other people. It will be noticed that there is no longer any place for the magistrate; while the mental welfare officer can organize and help in the process of admission, the onus of the recommendation lies in the hands of one or two medical practitioners.

In the normal course of an illness, the responsible medical officer will authorize the patient's discharge when he thinks the patient is fit to resume a more normal life. The next of kin can request his discharge, but this can be overrruled by the medical officer should he decide the patient would be a danger to himself or others outside

the hospital. Any three members of the hospital management can overrule the medical officer, and the final court of appeal is the Mental Health Review Tribunal. This body, consisting of at least three persons including a lawyer, a doctor, and a lay person, has the final say in the matter of detention or discharge.

The new system is bound to have its teething troubles, but it is far more considerate and humane than previous methods, and if the family doctor has to be more alert to the implications of psychiatry in his work, he will have the psychiatrist to help him in close collaboration. If the psychiatrist is given the chance to glance round the home in which the patient lives, seeing for instance his wife and family, this will tell him as much and more than the most elaborate history. Nothing but good can come from the domiciliary work which is bound to take place. The family doctor will learn more psychiatry, and the specialist will learn more about his patients and their background than ever before.

THE COLLEGE APPEAL

Many may ask why so short a time after the foundation of the College there is already a need for an appeal. The answer lies in the rapidly increasing responsibilities of general practitioners to the medical profession and to the community as a whole. It was a realization of these responsibilities which led to the foundation of the College in 1952. Since then its progress has been more rapid than anyone ever expected; so rapid, in fact, that future advance will be retarded and the very existence of the College jeopardized, if the financial resources do not increase proportionately.

The growth in size and stature of the College *Journal* alone and its increasing value to the family doctor is one indication of our rapid expansion. In the realm of research work much has been done, but only because of generous financial assistance from outside and the devoted self-sacrifice of members in both time and money. A glance at the report of the speech by Dr Rose, chairman of Council to the seventh annual meeting on page 85 will remind readers of the many and varied activities of the College, not only in this country but in all parts of the world.

The fact that the College is now recognized by all organizations connected with medical care as the authoritative non-political body which represents the general practitioner is clear evidence that it has reached a landmark in its history and that no bar to its future progress can be entertained. An increase in staff is now essential,