EDITORIALS

Compulsory admission to mental hospital

ASKED to give the matter of compulsory hospital admission calm and rational consideration, there can be few doctors who would not think it extraordinary that, in Britain today, people can be detained against their will, without recourse to the courts and without having any right of appeal prior to admission. Nevertheless, when faced with a dangerous schizophrenic at 11 o'clock on a winter's night, with the social worker untraceable and other calls waiting, one's views might tend to alter.

The problem is considerable. Although the percentage of compulsory admissions is small and steadily falling, the aggregate is high. Department of Health statistics for 1974 show that, of 183,265 admissions to mental hospitals in England alone, 23,732, or 12.9 per cent, were compulsory (DHSS, 1974). Such admissions are controlled by Part IV of the 1959 Mental Health Act. In summary, this part states that patients can be detained for certain limited periods in hospital on the grounds that they suffer from mental illness, psychopathy, subnormality or severe subnormality, and are a danger to themselves or others. This editorial will consider now Sections 25, 26 and 29 of the Act, as these are the three sections of prime importance to general practitioners.

The 1959 Mental Health Act

The Mental Health Act stemmed from the 1954-57 Royal Commission which considered two fundamentally different approaches to the problem of compulsory admission. The legalistic approach—as earlier exemplified by the 1890 Lunacy Act—implied that the same rights should apply whenever detention occurs, whether in hospital or prison, and whether the person is mentally ill or not; the approach based on the concept of treatment implied that a patient's need for treatment overrides his or her right to be represented by counsel and appear in court. Those who advocated the latter approach felt that mental illness is an illness, and that it was the prerogative of the medical profession, and no-one else, to decide who needs treatment and when this should be given. The Royal Commission accepted the treatment approach; this was a milestone in the medicalization of mental illness. The parallel change in public attitudes to psychiatric treatment, whereby mental hospitals came to be seen as institutions which treated diseases rather than places to keep troublesome lunatics out of circulation, further undermined traditional legal arguments. Understandably, but perhaps naively, it was felt that, as treatment was always of personal benefit to the individual, fewer safeguards would be necessary than if a more punitive concept were applied.

In today's more questioning society, it is astonishing that some of the legal features of the 1959 Act have not been more widely challenged and debated. It is surely surprising that the clinical assessments of medical recommendations do not have to be substantiated, that there is no right of legal appeal prior to admission and that it is legal to alter retrospectively documents relating to admission if they are found to be faulty.

Of course, a number of safeguards were built into the Act, and it is important to review them to decide whether they work. Having dispensed with the courts, the Act required the patient's relative and the mental welfare officer to make the application for admission, thereby intending to give the patient some protection. It also retained the requirement that for all sections except Section 29—which was intended for emergency use only—two doctors should be used; the second was to act as a check on the first.

The Act in practice

So much for the theory of the Act. What is happening in reality? A major new study by Bean (1980), an academic social scientist, makes stimulating reading. Realizing that he could not research the whole area of compulsory admissions, he examined in immense detail the way in which a small group of psychiatrists in an un-named hospital operated the 1959 Act. The hospital used a round-the-clock psychiatric intervention scheme, and he examined 325 cases to which the team was called. Of these, 58 were admitted compulsorily, 142 voluntarily; 125 were not admitted. As he points out, and as every doctor is aware, the distinction between voluntary and compulsory admission can be very blurred. A patient may be given the choice of voluntary admission, or be 'sectioned' if he refuses—a 'choice' which makes for simpler administration but which begs many ethical questions.

Section 29

So much important information has come out of this study that it is barely possible even to list it here. The area of most immediate interest to general practitioners is the use of Section 29. Perhaps the chief reason that doctors use this section is its speed. For valid and extremely practical reasons, many doctors would wish to have a patient admitted as soon as possible, and there is no doubt that finding a second doctor for Section 25 or 26 can be extremely time-consuming. However, Barton and Haider (1965) reported a study in which 13 of 25 Section 29 admissions were found to be unjustified. Paterson and Dabbs (1963) looked at a larger group and found that a third of Section 29 admissions became informal at the expiry of their 72 hours under section. Even allowing for the wonders of modern treatment, the authors asked if these admissions could not have been informal originally. In this new study, 21 of 32 patients admitted under Section 29 could be classified as being admitted against the spirit of the Act, which envisaged only very urgent cases being admitted under this section and when time is at a premium for the patient. Perhaps, in reality, it is being used mainly when time is at a premium for the doctor.

Taking all the sections of the Act together, Bean reached the disturbing conclusion that 53.4 per cent of all patients compulsorily admitted were detained against the spirit or rules of the legislation. He found that, on clearly determined evidence, all the psychiatrists in the study broke the rules. However, they did so because they were deliberately acting in the patient's best interests. In the case of the general practitioners, although sympathetic to their position, he had to concede that, when they broke the rules, they did so because they did not know what the rules were—an indictment if ever there was one.

The general practitioner

Dealing with Sections 25 and 26, the Mental Health Act envisaged that, as some form of protection for the patient in lieu of the courts, the opinion of a second doctor should be sought. Bean's study shows that the control the second doctor is supposed to offer is sadly inadequate. On an initial Section, the second doctor was almost always a general practitioner, and his signature turned out to be little more than a rubber stamping of the consultant opinion—hardly a control. As Bean says, "If not actually involved in a charade, the general practitioner's presence becomes dangerously close to it". Bean has little hope that postgraduate education can improve matters. As each general practitioner makes on average only one compulsory admission per year, he feels that there is little opportunity for him to develop expertise. He concludes that the requirements of the compulsory admission procedures are subordinated to the structural relationship between consultants and general practitioners.

The social worker

Social workers were also envisaged as a potential corrective to the influence of doctors, as it is they who make the actual application for admissions. Nevertheless, their role is ambiguous. If a doctor disagrees with a social worker's refusal to make an application, he can ask another social worker or the nearest relative to make it. If the relative agrees, the original social worker is still legally obligated to arrange the admission. It is understandable that social workers are dissatisfied. In a study of their attitudes to compulsory admissions, Danbury (1976) found that they felt they were inadequate and that they lacked knowledge, skill and experience. Indeed, most social workers in this study confessed that they hated doing compulsory admissions.

Bean analysed the knowledge and practical skills of the social workers involved with admissions to the study hospital and concluded that they have no expertise which qualifies them to do anything except the most simple and basic tasks in the compulsory admission procedure. His study of how well they cope in these circumstances will gratify many general practitioners, who in the past have barely disguised their irritation with inexperienced generic social workers, but his assessment of the general practitioner's own knowledge is no more flattering. Indeed, he quotes one psychiatrist who, revealingly, airs all his prejudices in the one sentence: "General practitioners are worse than social workers, for at least the general practitioners ought to know better".

In 1976, the DHSS published a consultative document reviewing the working of the Act (DHSS, 1976). It concluded that Sections 29 and 25 should be retained, but that the development of crisis intervention services should reduce the need for Section 29. In 1978 a White Paper looked at the rights and liberties of the mentally ill and at the power of the medical profession in relation to patients' rights. It concluded that, in nearly all cases, the law is scrupulously observed. Bean's study substantiates none of these conclusions or recommendations, nor would the various changes that the White Paper suggested make much practical difference to the way the law is actually administered.

Conclusions

This entire subject of admissions to mental hospital is fraught with problems that refuse to go away. Clearly, there are immense ethical and legal dilemmas in the way that the Act is currently being used. However, if we adopt the views of the anti-psychiatrists, there can be no doubt that the admission of many seriously ill patients would be delayed and their own, and their relatives', suffering would be much greater. In America, this may have already happened. As Treffert (1973) put it: "In the zeal to impeccably protect the patient's civil liberties and rights, an increasing number of troubled and psychotic patients are dying with their rights on." He

continued "The pendulum is swinging from frank paternalism to frank abandonment." Neither of these is acceptable. Nevertheless, because the power society has given us is immense, as a profession we should be prepared to justify our opinions to outside agencies. Deciding between our responsibility to an individual and our responsibility to society can be a problem in all areas of medicine; nowhere is this more true than in this aspect of psychiatry.

This important study, small though it may be, begs important questions about general practitioner knowledge and attitudes. It is true that Bean did not analyse general practitioner admissions in great detail, and it may be that by chance he selected general practitioners with below average psychiatric skills who were more subservient to consultant opinions than average, but to use such an argument is to bury our heads in the sand. Not only is it unprovable, but it is probably not even true. Bean does, however, paint an unnecessarily bleak picture for the future. As more and more general practitioners become vocationally trained, and as vocational training includes more psychiatry, skills may well increase.

References

Barton, R. & Haider, I. (1965). Misuse of Section 29. *Lancet*, **1**, 912.

Bean, P. (1980). *Compulsory Admissions to Mental Hospital.* London: John Wiley.

Danbury, H. (1976). Mental health compulsory admissions. *Social Work Today*, **7**, 172-74.

Department of Health and Social Security (1974). *Inpatient statistics from the Mental Health Enquiry for England.* Statistical and Research Report, Series No 17. London: HMSO.

Department of Health and Social Security (1976). *A Review of the Mental Health Act 1959.* London: HMSO.

Paterson, H. F. & Dabbs, A. R. (1963). *British Journal of Psychiatry*, **109**, 202-205.

Treffert, D. A. (1973). Dying with their rights on. *American Journal of Psychiatry*, **130**, 1041.

Measuring the quality of general practitioner care

THE idea of defining and measuring the quality of general practitioner care has been one of the intellectual preoccupations of general practitioners for at least 25 years. The stated aim of the Royal College of General Practitioners is "to encourage, foster and maintain the highest possible standards in general medical practice", yet the highest standards prove elusive to measure and hard to find.

One obvious starting point is to review the literature on this difficult subject. This has now been done by Dr C. J. Watkins, one of the senior lecturers in general practice at the General Practice Teaching and Research Unit at St Thomas' Hospital Medical School, London. Dr Watkins' work originally formed part of his successful PhD thesis, and his review of the literature published as *Occasional Paper 15* now makes it possible for all interested in this fascinating subject to cover the ground that has at least already been cultivated.

Classifying his paper under the traditional headings of adequate access, adequate process and adequate outcome, Dr Watkins discusses the many difficulties which arise when trying to measure the quality of care, and he includes about three pages of references on this important subject.

General practitioners need not be surprised if they find the definition of standards, let alone their implementation, remarkably difficult. Watkins quotes Professor Dudley's findings that it took a small group of London teaching hospital surgeons no fewer than 18 separate meetings before they could agree on a policy for the management of patients with upper gastrointestinal bleeding after admission. Given the sensitive doctor/patient relationship and the immense variety of problems presenting in primary medical care, it is clear that the measurement of quality in general practice is going to be infinitely more difficult.

Nevertheless, the hunt is on and there can be no doubt that many individual practitioners and a number of organizations, including the Royal College of General Practitioners, are now irrevocably committed to defining and measuring quality in general practice. *Occasional Paper 15* can be recommended as a valuable starting point for others interested in joining this search.

The Measurement of the Quality of General Practitioner Care, Occasional Paper 15, is available now from the Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU, price £3.00 including postage. Payment should be made with order.