A systematic review of research relating to the Mental Health Act (1983)

Authors
Rachel Churchill (2)
Sharon Wall (1)
Matthew Hotopf (1)
Alec Buchanan (3)
Simon Wessely (1)

Address for correspondence
Rachel Churchill
Senior Research Fellow in HSR
St George's Hospital Medical School
Health Care Evaluation Unit
Department of Public Health Sciences
Cranmer Terrace
London SW17 0RE

[1] King's College School of Medicine and Dentistry, Denmark Hill, London SE5 8AF

[2] St George's Hospital Medical School, Tooting, London SW17 0RE

[3] Institute of Psychiatry, Camberwell, London SE5 8AF

Table of Contents

Table of Figures

List of Tables

Preface

The Mental Health Act (1959), often heralded as a major example of enlightened social welfare legislation, was widely influential in North America, Europe and the Commonwealth. The clear trend was towards informality and medical discretion and away from judicially ordered civil commitment. Impetus for reform of the Act came partly from public enquiries, particularly the St. Augustine's Report, which not only criticised conditions, but also the use of unlawful restraint and treatment without consent. Research supported the general findings of the enquiries, which indicated that safeguards were not always working well. In 1975 the Report of the Butler Committee on Mentally Disordered Abnormal Offenders and the MIND Report *A Human Condition* were both published setting the framework for the debate which was to follow. Following the publication of a Consultative Document in 1976, two further contributions were published. The first was the second volume of *A Human Condition* published by MIND in 1977, and the second was *Mental Health Crisis Services - A New Philosophy*, produced by the British Association of Social Workers. In 1978 a consultative paper was published on Mental Health Review Tribunals. The law relating to mentally disordered persons was consolidated in the Mental Health Act (1983).

The Mental Health Act (1983) (MHA) is an important legislative process intended to ensure a consistent and comprehensive approach to psychiatric care in England and Wales. In the 15 years since the MHA was introduced, mental health service provision has radically changed involving widespread hospital closures and the introduction of care in the community. There have been calls for changes in the legislation to reflect these changes in service provision. The use of, and procedures associated with, the Act have been much debated although there has been no systematic and objective review of the Act since its introduction 16 years ago. The Department of Health (DH) have commissioned King's College School of Medicine and Dentistry to synthesise the data pertaining to the Act. The primary focus of this project will be to gather and evaluate information on Parts II, III and X of the Act. The primary sources of such information will consist of data provided by the DH, analysed and discussed in conjunction with a review of the available literature. The report includes an examination of specific problematic areas of the Act, the outcomes of various aspects of the Act, trends in the use of the Act over time, the quality and quantity of studies reviewed, and areas of investigation and data collection which are currently incomplete.

Executive summary

Part 1 of the report

- Data collected by the Department of Health between 1984 and 1996 shows a dramatic rise in the absolute number and proportion of formal admissions.
- Most of this increase is accounted for by an increase in the use of Part II of the Act. Whilst Part III admissions have increased, the rise is modest by comparison.
- Within Part II there is a steady increase in admissions on Section 2, an increase in the use of Section 3, and a decrease in admissions on Section 4.
- Within Part III there is a fall in the use of Section 37 and a rise in Section 47/48.
- For Part X, there has been a drop in the total number of Section 136 until 1990 followed by a subsequent increase.
- The most common section applied to patients already admitted to hospital is Section 5(2). These have risen steadily since 1983. Most Sections 5(2) are left to lapse, but there has been an increase in conversions from Section 5(2) to Section 3.
- For Section 4, there has been a reduction in conversions to informal status, and an increase in conversions to Section 3.

Part 2: Chapter 1. The systematic review

- The aim of this review was to undertake a systematic search and evaluation of all data pertaining to the MHA. The review was intended to provide an objective summary of the data pertaining to the Act as a whole and its different parts, identifying specific aspects of the Act which appear to work effectively and highlighting aspects which appeared problematic or ineffective.

- A total of 171 journals and 708 papers were identified from a range of sources.

- Applying the inclusion criteria, 560 articles were excluded because they contained no data.

- The remaining 148 articles related to the Act as follows:

The Mental Health Act (MHA) as a whole		20
Part II of the MHA		46
Part III of the MHA		23
Part X of the MHA		29
Miscellaneous topics as follows:	(i) The use of ECT	4
	(ii) Violence and the MHA	3
	(iii) Aftercare in the MHA	2
	(iv) Care of the elderly	5
	(v) Forensic settings	6
	(vi) Mental impairment	2
	(vii) Adolescent unit	1
	(viii) Interdisciplinary use of the MHA	6
	(ix) Training in the use of the MHA	1

- A large number of articles identified provided information on variations in practice and deviations from the Act according to ethnic group, geographic location and other demographic variables, and outcomes of various aspects of the Act.

- Relatively little information was available on the use of appeals and different types of appeal, the use of treatment/discharge plans and the use of consent forms.

Part 2: Chapter 2. The use of the Mental Health Act (MHA) as a whole

- Three key questions have been addressed in the literature: (a) frequency of the use of the MHA; (b) the characteristics of patients detained under the MHA; (c) the outcomes of use of MHA.

(a) Frequency of use of the MHA – summary of literature

- As has already been addressed in Part 1 the first part of this report, crude figures disguise the experience of many patients with chronic or relapsing and remitting illness who are admitted much more frequently. As a result, contradictory figures were found in the literature.
- Among patients known to general adult psychiatric services, studies indicate that – in urban populations at least – most patients with psychotic illness will be formally admitted at some point in the course of their illness.
- Only one paper we identified assessed secular trends in the use of the MHA. This paper – which studied an inner city catchment area - showed an increase in the proportion of formal admissions rising from 28% to 44% over a three year period (1986-1988). This accords with the findings of the Part 1 of this report.
- One paper reported that 63% of social worker assessments led to the patient being sectioned, and that a higher proportion of patients were sectioned (81%) when the request came from a psychiatrist.
- The Act is being used more frequently, and - for urban centres at least - most patients with psychotic illness are likely to experience being detained under the MHA at some point in their illness.

(b) Characteristics of patients detained under the MHA – summary of literature

- A consistent finding is that males are more likely to be sectioned than females.
- There is also good evidence that the proportion of admissions under the MHA fall with the age of the patient group studied.
- The most widely studied and important demographic variable in relation to the use of the MHA is ethnicity.
- The general pattern is remarkably consistent - black individuals are considerably more likely to be admitted formally than are whites.
- Little research on Asian groups - that which was identified suggested Asian groups have intermediate rates of formal admissions.
- On average, studies indicate black individuals with psychiatric disorders are approximately twice as likely to be detained against their will than their white counterparts.
- A potential reason for this is confounding by age assuming that black people with psychotic illness are, on average, younger than white people with the same illnesses.

- Other such confounders have been suggested including diagnoses of schizophrenia and presentations with challenging behaviour. Also possible that some of the differences between black and white groups may be due to prior contact with services.
- Not many studies have assessed the role of diagnostic group as a predictor of formal admission.
- Diagnoses associated with lack of insight, poor self care and threatened violence to others appear to be more likely to lead to formal admission.

(c) Outcomes of the use of the MHA – summary of literature

- These are mainly studies assessing the patients' views of their experiences rather than formal studies assessing clinical outcomes associated with the use of the Act - therefore any differences between patients detained under the MHA and informal patients may be the result of confounding by diagnostic group and illness severity.
- Clinicians may avoid using the MHA because the future clinical relationship with the patient might be damaged - strong evidence that patients resent being sectioned at the time when it happens.
- Interestingly - many patients admitted informally also saw their admission as coercive – believing that were they to refuse treatment, they would have been admitted under the MHA.
- Sectioned patients and their families have been shown to be less satisfied with all aspects of their care and a number of specific domains of care, including treatment information and its benefits, the ward facilities, the humane aspects of treatment.
- One study presents an alternative picture, once more suggesting ethnic differences. Only a minority of white patients felt the section was inappropriate and only a quarter reported anger about their experience at follow-up; many more black patients reported anger and the majority felt the detention had been wrong.
- A similar study found that only a minority of patients were resentful about their admission but the view was dependent on the treatment received. Patients treated against their will were more likely to feel resentful, especially those given electro-convulsive therapy (ECT).

Future research

- Routine data do not give any information on the individual patients involved and at present no satisfactory denominator data exist.
- One alternative is to identify well-defined patient groups and to follow them over time.
- It would also be useful to have data on patients with alternative psychiatric diagnoses such as recurrent depressive disorders and personality disorders.
- Further studies might address the use of the MHA in other situations (for example patients presenting with self harm).
- More data is required on the use of the Act in rural settings and in alternative urban centres.

- There is a pressing need for research into reasons for the association between ethnicity and use of the MHA.
- The non-randomised assessments of patient satisfaction preferred to have compared patients according to whether they were admitted formally or informally. A more clinically relevant comparison would be that made between patients assessed for sectioning who are detained and those who are not detained, reflecting the dilemma psychiatrists and social workers find themselves in when assessing acutely disturbed patients in community settings.

Part 2: Chapter 3. Part II of the Mental Health Act

- No studies were identified relating specifically to Section 4.
- The studies reviewed in this chapter centred around several main themes: Section 2 - Factors governing the likelihood of appeal under Section 2; Section 3 - Patient discharge and extended leave; Section 5(2) - Appropriateness of application and implementation of Section 5(2); Section 5(4) - Factors affecting how and when Section 5(4) is applied; Part II as a whole - (a) Trends in the implementation of Part II, (b) Characteristics of patients detained under Part II, (c) Outcomes associated with the use of Part II, (d) Interdisciplinary implementation of Part II.

Part II: Section 2 - Factors governing the likelihood of appeal under Section 2 – summary of literature

- Different rates of appeal under Section 2 have been reported and factors governing likelihood of appeal have been examined.
- Appeals have been shown to be more likely to be female (despite approximately even numbers of males and females being detained under this section).
- Nearly 12% of appeals are by patients of Asian origin.
- The findings of one study were that the majority of appeals were to a Mental Health Review Tribunal - two-thirds of all appeals reached hearing with 12.3% of these being discharged. However, these findings have been much disputed in the literature, involving criticisms to the study methodology and questions as to the generalisability of the results.
- It has been suggested that the current appeals procedure may discriminate against certain groups of patients, potentially favouring only well educated or previously admitted patients.
- It is also suggested that a diagnosis of depression or dementia or not receiving the information booklet reduces the likelihood of appeal.
- There are concerns about the methods for informing patients of their rights when on a section - other approaches to the appeals procedure have been suggested.

Part II: Section 3 - Patient discharge and extended leave – summary of literature

- Like the DH figures, the literature suggests that since 1988, Section 3 orders have risen and that more patients have been detained for longer than 33 weeks. It is suggested that Section 3 might be being used in preference to Section 2.
- One study found a significant reduction in the numbers detained for over 13 weeks and a trend towards earlier discharge, perhaps suggesting less ill people were being sectioned and reflecting pressure on beds.

- Factors suggested as being associated with extended leave patients were a history of persistently poor compliance with treatment including outpatient attendance, a more frequent history of serious dangerousness, and numerous admissions.
- There may be a group of psychiatric patients who benefit from extended leave in whom the outcome would be poor without the possibility of compulsory outpatient treatment.

Part II: Section 5(2) - Appropriateness of application and implementation of Section 5(2) – summary of literature

- These studies produced conflicting findings.
- Although most studies found that the majority of sections were implemented outside office hours and more than 24 hours after admission, two studies found the reverse, with the majority of sections being implemented within 12 or 24 hours of admission.
- There was little evidence of abuse of Section 5(2) as an expedient measure to detain patients.
- It is seen as an acceptable means of short detention – perhaps indicating the need for a short period of detention in times of crisis.
- Inappropriate use of Section 5(2) was however suggested, particularly in relation to the high numbers not converted to either Sections 2 or 3.
- Some evidence that patients were more likely to be converted to either Section 2 or 3 if there was evidence of mental illness or suicidal ideation, if the section had been preceded by a Section 5(4), or if the section was invoked by a senior psychiatrist.
- Reasons for conversion or non-conversion of a section were often poorly documented and better documentation procedures and improved training of doctors in relation to the assessment and conversion of Section 5(2) are recommended.
- Differences in the organisation of services throughout the country lead to variation in who is available and qualified to be the nominated deputy, with most sections being applied by junior doctors, many of whom are not in contact with consultants.
- It has been suggested that Section 5(2) is often implemented or signed by the consultant, raising queries as to why Sections 2 or 3 were not implemented in the first place.

Part II: Section 5(4) - Factors affecting how & when Section 5(4) applied –summary of literature

- The commonly held belief that Section 5(4) is used most at weekends was not empirically supported, with a large amount of sections being applied during office hours.
- One study reported that many doctors were absent from the wards when Sections 5(4) were implemented and an RMO might have been available.
- A high number of Sections 5(4) were reported to be implemented on the day of admission.

- Contributing factors in the implementation of this section include high patient-staff ratio, increase in patient-patient interaction, no RMO, visiting period.
- Reasons for not finding the power useful included 'too much responsibility for a RMN' and 'too much trouble for 6 hours'.
- Most nurses felt 5(4) ensured their legal protection, but were more reluctant to use their powers than likely to abuse them, often preferring to persuade the patient to stay on an informal basis.
- A need for increased training in risk assessment skills and increased communication between agencies with the multi-disciplinary team in terms of patients' previous histories was suggested.
- Many patients are unaware/do not believe that nurses have this power.
- Social workers were often uncomfortable about the use of this section; doctors were inclined to support its use by nurses.
- It was noted that in emergency situations nurses should apply 5(4) rather than common law, but that the patient detained under 5(4) has no legal right to appeal against it.
- The most common outcome of the use of Section 5(4) was for a Section 5(2) to be implemented.
- It is possible that Section 5(4) is under-used - very low rates of use and the fact that the majority of these sections are converted indicates that nurses' powers are unlikely to be abused. Also little evidence to suggest any changes in the numbers of patients who abscond under this section.

All of Part II

- Several main themes could be identified in these studies which generally mirrored topics discussed in other chapters of this report.

(a) Trends in the implementation of Part II – summary of literature

- Many of the studies highlight limitations of DH data in estimating the extent and frequency of use of MHA - could partially explain discrepancies between many reported findings.
- Some studies report that Section 2 requests have remained stable, Section 3 requests have risen, and Section 4 requests have decreased.
- Overall, as noted in Part 1 of this report, the use of Section 3 is reported to have increased and Section 4 decreased.
- The increase in Section 3 use might be explained by the need to renew the detention of some patients after 6 months rather than just one year.
- The increase in Section 4 admissions is balanced out by the low use of Section 136 in low density urban populations and area with low proportions of ethnic minorities as well as good social worker support.

(b) Characteristics of patients detained under Part II – summary of literature

- Factors reported to affect the use of Part II and the outcomes associated with it, include characteristics of patients, attitudes of professionals, as well as the absence of a clear definition of mental illness.
- Age and gender were identified as key variables in the identification of mental illness with younger men and older women characterising the population.
- One report suggested that although patients over 65 years made up one fifth of referrals, they were less likely to be detained.
- A close relationship was reported between Section 4 and an index of social deprivation, but only in London authorities.
- Those in unpaid employment were reported to constitute nearly three quarters of all those referred.
- Although there are inconsistencies in the literature, it is likely that the majority of Section 4 requests lead to compulsory detention.
- One report showed an increasing number of assessments involving younger men with schizophrenia, commonly the same men repeatedly, suggesting this largely accounts for overall increases in the use of the Act.
- Other figures indicate a greater likelihood of detention following assessment for patients already in hospital than for the group as a whole.
- One study suggested that voluntary services were used to prevent hospital admission more in black than white patients.
- Echoing the observations made in Chapter 2 of this report, the same study indicated that Asians referrals were more likely to come from GPs or psychiatrists but referrals of black people more likely to come from the courts or the police. A possible reason is differences in diagnoses and presentation.

(c) Outcomes

- Over half of Section 4 patients were were reported to have been converted to informal status, but patients regraded from Section 4 had a significantly longer stay in hospital than informal patients.
- One study reported that Sections 5(4) were often either converted to Sections 5(2) or to informal status.
- One study showed that Section 2 was often left to expire.

- The same study reported that the number of MHRT hearings rose dramatically following the introduction of the MHA (1983), although they resulted in few discharges before and after the Act.

(d) Interdisciplinary implementation of Part II

- Ways in which the Act is applied by different professional groups has received some attention, but there is variability in the availability of information from different professional groups, with ASWs showing great flexibility in their responses.
- Considerable variation was found between authorities in terms of making applications under the Act.
- Specific requests for detention more often resulted in detention than did general requests for assessment, but individual policies and practices of agencies were reported to affect the number of requests for detention.
- Despite the detailed studies provided by local authorities, the differences between them made it difficult to draw any conclusions - several authors called for a standardisation of data collection.
- Section 3 patients were found to be most likely to be detained by agreement of ASW - these referrals were often well known to services.
- Social workers were reported to be less likely to agree to admission in response to requests for Section 4 with a high rate of Section 2 and Section 4 referrals being persuaded to enter hospital informally.
- One study reported that one third of Section 4 requests were detained under Sections 2 or 3.

Part 2: Chapter 4 – Part III of the Mental Health Act (1983)

- Most articles described the way the Act is used in court, in prisons and in secure hospitals and describe groups of patients in terms of their socio-demographic characteristics.

(i) Facilities and resources – summary of literature

- Many mentally disordered people are being assessed, treated, or simply ignored in prison.
- Special Care Units (SCUs) have relieved some of the pressure on Regional Secure Units (RSUs).
- RSUs in turn are taking more patients instead of Special Hospitals.
- The time between arrest and admission was much shorter where court liaison schemes operate and the number of days spent in custody was reduced whether the patient was sent to hospital or not.
- All hospitals provide beds for Part II orders on the day they are made. However, this not necessarily the case for Part III, unless partnership with a liaison scheme.
- Reception screening by the prison service is neither sensitive nor specific in detecting mental disorder.
- The incentive to improve matters is reduced because treatment options are so limited.
- Prisoners with personality disorder or sexual deviancy failed to reach hospital because of disagreements between doctors over treatability and security of facilities.
- There is some concern over the lack of suitable facilities for mentally ill patients with mild and borderline intelligence.
- There were some racial differences in the implementation of the Act with Afro-Caribbeans being over-represented among prison transfers when compared with the prison population as a whole.
- Of those detained under Section 47, significantly more non-white patients are given a diagnosis of psychotic illness as opposed to personality disorder.

(ii) The usefulness and appropriateness of individual sections of the Act – summary of literature

- Sections 35 and 36 appear to be used interchangeably through a gradual process of parliamentary legislation.
- That Sections 35 and 36 are leading to more hospital orders being made.
- Delays were observed in the transfer of mentally ill prisoners under Section 47.
- There were considerable regional and inter-regional variations in the use of Section 47.
- In the use of Section 47, the need to expedite treatment in advance of the earliest date of release may lead to priority being afforded those with fixed sentences.
- Although those transferred toward the end of their sentences had shorter sentences, their length of stay in hospital did not differ.

- There was little evidence that the Section 47 transfer was used to lengthen a sentence and no evidence that the time spent in hospital reflected the gravity of the offence.
- One study showed that where Sections 37 and 38 were used, half of the prisoners studied were shown to have been disposed of by the courts before a visit could be arranged.
- There was concern over those who may be asymptomatically ill during remand, thus escaping medical notice.
- Men not referred for outside assessment spent the least time in prison and those accepted for a bed the longest.
- No difference was found in the length of stay between psychotic and non-psychotic prisoners.
- In relation to Section 41, the proportion of people receiving a restriction order compared to the number guilty of indictable crime is small.
- Special Hospitals were shown to accommodate more than half of restricted patients, possibly due to the feeling that local hospitals are not equipped to deal with such patients.
- More violent offences were committed amongst the restricted population compared to unrestricted.
- Less females were found to be subject to restriction orders than to unrestricted orders.
- 20% of defendants referred to the court liaison service are later committed to stand trial in Crown Court – a proportion may benefit from the urgent treatment provision of Section 48 - it has been suggested that Section 48 is underused.
- One anomaly was that a Magistrates Court plays no part in the implementation of Section 48 but must authorise its termination.
- Design and methodological issues limit the use of existing research into Part III.
- The prospect of capacity-based legislation has particular relevance to Part III, since it raises issues around securing public protection once a patient regains capacity to make decisions.

Part 2: Chapter 5 - Part X of the Mental Health Act (1983)

- This chapter is centred around three main themes arising from the literature: (a) the characteristics of those detained under Sections 135 and 136; (b) is Section 136 being implemented appropriately?; (c) Are professional relationships affecting the implementation of Section 136?

(a) Characteristics of those detained under Sections 135 and 136 – summary of literature

- Section 136 detentions are more common in urban populations.
- Detainees are more likely to be young, male, violent and suffering from schizophrenia.
- Section 136 detentions are higher in the black population.
- Three studies found no differences in outcome between ethnic groups
- Several authors found no evidence of differences in the behaviour of the police implementing Section 136 in different ethnic groups.

(b) Is Section 136 implemented appropriately? – summary of literature

- A high number of Section 136 arrests are made on private premises.
- Police were found to be using alternative methods in order to implement Section 136.
- There is a belief in, and use of Section 136 as a three day admission section and the police were considered to be the only 24 hour service available highlighting the lack of voluntary or statutory services out of hours.
- Alongside claims of the inappropriate use of Section 136, a number of studies reported the police to be generally correct in their decisions to refer people for assessment – these studies highlighted a lack of formal policies and confidence by the police in the use of this section.
- The information recorded by the police regarding Section 136 detentions was minimal, potentially affecting the accuracy of observed trends in its use - one possible reason the over-representation of Section 136 in London is that other areas rarely record its use unless the patient is admitted.

(c) Are professional relationships affecting the implementation? – summary of literature

- Poor relations and general mistrust between police, psychiatrists and social workers widely acknowledged.
- In general, police and psychiatrists perceived a lack of ASW involvement in implementing Section 136.
- Resource pressure influenced the involvement of all three agencies. For the police, mental health problems often involved non-criminal or minor offences, yet used more police resources than burglaries, thus diverting police resources away from more serious crimes.
- A number of hospitals were found to be refusing Section 136 referrals on the basis of bed shortages.
- The police station was not viewed as a suitable Place of Safety.

- Specialist Emergency Assessment Units were regarded as better at assessments and providing a wider range of disposals than hospitals.
- Section 136 is being used in ways more appropriate to Section 135.

Future research

- The observation that Section 136 is being used in ways more appropriate to Section 135 requires further examination.
- Further research into the over-representation of ethnic and homeless groups in detentions under Part X is needed.

Part 2: Chapter 6 Miscellany

- This chapter describes some papers that are not easily placed elsewhere in the review. Nine specific issues were covered by these miscellaneous papers.

(i) The use of ECT under the MHA – summary of literature

- Few papers have specifically assessed the use of ECT under the Act.
- One audit of treatments for depression in an elderly ward found that 7 out of 11 patients given ECT had it against their will.
- It is not clear whether ECT against the patient's will is associated with a poorer outcome.

(ii) Violence and the MHA – summary of literature

- Violent behaviour is associated with the use of the MHA.
- One study suggested violent incidents may be more common in formal patients – but the majority of assaults occurring in this psychiatric unit were by informal patients.
- There is some evidence that decisions related to sectioning patients were very rarely antecedents to violent acts.
- One study found the rate of violent incidents fell when the number of mentally disordered offenders rose – this study did not control for any confounders - results difficult to interpret or generalise.

(iii) Aftercare in the MHA – summary of literature

- There is remarkably little written about the outcome of patients who have been detained.
- One study found that psychiatric case-notes were less likely to contain the GP's name and address and that psychiatric patients were less likely to be able to remember them - sectioned patients were especially likely to not know their GP's details.
- It is possible that those with the most complex needs had the poorest provision during their admission.

(iv) Care of the elderly

- Only one study looked at the proportion of all admissions to psychogeriatric units under the MHA – estimated to be approximately 5%.
- Most of the studies simply described the characteristics of elderly detained patients.
- One exception found a higher proportion of elderly sectioned patients were female; that self-neglect was a common reason for sectioning in the elderly but not the young; and that dementia – which was not diagnosed in the young group, was a common diagnosis in the older sectioned patients.
- Self-neglect is an important reason for sectioning in this group, especially in those living alone.

- Sectioned patients with dementia are more likely to be placed on briefer sections – patients placed on a Section 5(2) are less likely to be converted onto a Section 2 or Section 3, and the use of Section 3 is more common in those with functional psychosis than dementia.
- Among patients living at home with carers, the commonest reason for admission was that the carer could no longer cope.
- One study found that less than half of all elderly patients detained on the MHA return to their home, with many going into residential care and nearly 10% dying during their admission.
- The lack of comparative data with non-sectioned patients make these findings difficult to interpret.

(v) Forensic settings

- Nearly all patients treated in forensic settings are detained under Parts II or III of the MHA.
- One study described the knowledge patients had of their voting rights and found this to be poor - the majority had not voted and most did not know whether they were entitled to vote.
- One study assessing the use of medication in a regional secure unit (RSU) found medication was given to prevent or contain physical aggression in nearly one half of cases.
- Three other papers mainly aim to describe the workings of forensic units - data on the MHA are incidental to their main findings.

(vi) Mental impairment

- One study examined the characteristics of all patients detained in the West Midlands under mental impairment or severe mental impairment categories - most were in mental handicap hospitals, but a sizeable minority were in special hospitals. The majority were detained for criminal offences and a subgroup were also suffering from schizophrenia.
- One study reported that a high proportion of sectioned patients with learning disabilities had additional psychiatric diagnoses and that the majority of relatives and carers supported the section when it was applied.

(vii) Adolescent unit

- One study indicated the use of the Act was less frequent in an adolescent unit than in general adult psychiatric settings – the most common reason for detention was risk of harm to the patient.

(viii) Interdisciplinary use of the MHA

- A randomised controlled trial of GP education failed to show any effect of the intervention on total admissions or admissions under the MHA - however - statistical power may have been insufficient due to relatively rare outcomes.

- Conflict can arise when professionals have different views regarding the appropriateness of formal admission.
- There may be a general trend for psychiatrists to be most likely to recommend formal admissions and ASWs to be more cautious, with GPs falling somewhere between.
- A study describing actual cases where social workers had not supported psychiatrists' recommendations for patients to be detained reported about one half of such patients were subsequently admitted to hospital and that those who were not immediately sectioned were judged to have a worse outcome at three months.
- A study describing referrals for sectioning made by GPs to psychiatrists compared to ordinary referrals showed, unsurprisingly that those referred for sectioning were more likely to be clearcut cases of psychiatric disorder, and considerably more likely to have psychotic illness.
- When compared with referrals for sectioning from other agencies (eg social workers, and police), GP referrals may be less likely to lead to compulsory admissions.

(ix) Training in the use of the MHA

- Only one paper addressed this issue - less than half the senior registrars in psychiatry questioned reported ever having received formal training in the use of the MHA.

Part 1: Analysis of Secular Trends in the use of the Mental Health Act (1983) in England from 1984-1996

1.1 Introduction

In this part of the review, we report analyses performed on Department of Health data on the use of the Mental Health Act (1983) (MHA) over time. So far these data have not been widely disseminated, and this section of the report is an attempt to describe and explore broad changes of the use of the Act. We explore changes in the use of the Act in more detail, breaking down the use of the Act according to Sections.

1.2 Methods

All formal admissions received by the any hospital in England are routinely forwarded to the Department of Health (DH). The DH data breaks down the use of sections of MHA into the following categories:

1. The type of section used (eg Section 2, 3 etc).
2. Whether the section was used to admit a patient or applied to a patient already in hospital.
3. Whether it was a new section, or one section being converted into another (eg a Section 5(2) being converted into a Section 2).
4. Where the section was applied.
5. The year the section was applied.

Information from the DH were only available for England: Scotland and Northern Ireland have different laws, and data were only available in Wales from 1991 to 1997. Therefore we limited our analyses to data for England. The DH data did not separate Sections 47 and 48, so these data were obtained from the Home Office.

In order to determine the proportion of detained patients admitted to hospital, denominator data of psychiatric hospital admissions were obtained from the DH Mental Health Division. From 1984 to 1986 data were available via the Mental Health Enquiry. This was a national survey of all psychiatric hospital admissions. Data from 1989 to 1996 were obtained from the Hospital Episodes Statistics system. For three years (1986-1989) information were not available: this was a period of transition between the two types of data collection. The data obtained at this time was thought to be of poor

quality. In order to gain denominator data for the forensic sections used on prisoners, we used Home Office statistics on the average prison populations for each year.

Data are presented as the total number of sections applied in each year for each section, and the proportion of admissions for which patients were sectioned.

1.3 Results

1.3.1 All admissions

Figure one gives an overview of all formal admissions to NHS facilities, private mental nursing homes and special hospitals. The number of total formal admissions increased gradually from 1984 to 1991 by an average 500 new admissions per year. From 1992 to 1996 this accelerated to an increase of 1500 new admissions per year. Total Part II admissions form the largest proportion of all formal admissions, and appear to have had the strongest influence on the overall trend. Court and Prison admissions (Part III of the Act) appear to have varied little over the 11 year period, however there have been important changes (see below). Place of Safety Orders (Part X: Sections 135 and 136) declined gradually from 2000 admissions per year in 1984 to 1000 in 1990/91. The number of such orders then rose again to 2000 in 1995/96. During the same period there was an increase in the number of psychiatric hospital admissions each year, from 190,389 in 1984 to 213,240 in 1996.

1.3.2 Use of Part II of the Act

Figure two demonstrates the changes in absolute numbers of people admitted under different sections of Part II of the Act. The main findings are that the absolute numbers of patients admitted on Sections 2 and 3 have increased, and those admitted on Section 4 have fallen. As a proportion of all admissions, admissions on Section 2 have risen from 3.7% to 5.4% between 1984 and 1996, and admissions on Section 3 have risen from 1.0% to 4.3% over the same period. Meanwhile admissions on Section 4 have fallen from 1.9% to 0.7% of all psychiatric hospital admissions.

1.3.3 Use of Part III of the Act

Part III of the MHA covers the main forensic sections. Court and prison admissions account for less than 10% of all formal admissions. There was an overall increase in the use of Part III. Between 1989 and 1992 admissions rose from under 1500 per annum to over 2000. Figure three shows the use of individual sections in Part III. There are a number of striking changes over this time period. Section 47 (transfer of sentenced prisoners to hospital) more than doubled from 103 in 1987 to 264 in 1996. Section 48 (transfer of untried or unsentenced prisoners to hospital) rose from 77 per year to 481 in the

same period – a more than six-fold increase. Section 37 (hospital orders) decreased from nearly 1194 in 1984 to just over 749 in 1996. Using data provided by the Home Office, we used the average annual population of sentenced prisoners as the denominator for Section 47s, and the average annual population of unsentenced prisoners as the denominator for Section 48. The results are shown in figure four. Despite an increase in the prison population during this period, the proportion of prisoners transferred on each Section rose, with a particularly marked increase in the use of Section 48.

1.3.4 Changes from informal to formal status

Figure five shows trends in sections for informal in-patients. The most widely used section for informal patients is Section 5(2) (doctor's holding power). This has increased nearly two-fold from over 5000 per annum to just under 9000. By contrast the use of Section 5(4) (nurse's holding power) has always been infrequently used, and there was little change over the last twelve years. There was a change in the pattern of use of Sections 2 and 3 for previously informal patients. At first, both sections were applied equally to informal patients, until 1992 when Section 3 became increasingly the preferred option. This appears to mirror the rise in the use of Section 3 to admit patients to hospital.

1.3.5 Changes from Section 5(2) to informal status and other sections

Figure six demonstrates the changes experienced by those patients on a Section 5(2) once the section had lapsed or been altered. The majority of 5(2) sections were allowed to lapse to informal status. There was a sharp increase in the number of patients changed from Section 5(2) to Section 3.

1.3.6 Changes from Section 4 to informal status and other sections

Figure seven shows the disposal of patients admitted on Section 4. Over time, many more patients admitted on this section were transferred onto a Section 3, with a decrease in the proportion of Section 4 patients whose sections were allowed to lapse to informal status.

1.4 Discussion

1.4.1 Summary of main findings

There has been a dramatic rise in the absolute number of formal admissions and the proportion of all psychiatric admissions which are formal. This increase was largely accounted for by an increase in the use of Part II of the Act. Whilst total Part III admissions have increased, the rise in terms of absolute numbers is modest by comparison. Within Part II there was a steady increase in admissions on Section 2, an increase in the use of Section 3, and an absolute and relative decrease in admissions on Section 4. Within Part III there was a fall in the use of Section 37 and a rise in Section 47 and Section 48. For

Part X, there has been a drop in the total number of Section 136 until 1990 followed by a subsequent increase. There has been a steady rise in the use of Section 5(2) since 1983. Most Sections 5(2) are left to lapse or are rescinded, but there has been an increase in conversions from Section 5(2) to Section3. For Section 4, there has been a reduction in conversions to informal status, and an increase in conversions to Section 3.

1.4.2 Methodological weaknesses

These data are potentially unreliable (Nemitz & Bean, 1995). They depend upon relevant NHS Trusts reporting sections to the DH when they occur. It is therefore possible that changes in the efficiency with which sections are reported could account for the total rise in formal admissions. However there are a number of reasons why this explanation is unlikely to account for these results. Firstly, the total number of formal admissions rose year on year – it seems likely that increases in the proportion of sections being accurately reported would increase more suddenly as a result of a drive to improve data collection. Secondly, the period between 1984 and 1996 was one of great changes in the organisation of healthcare. During this time NHS trusts were established, and many of these have since merged. It is likely that the disruption these changes involved, would have *reduced* the proportion of sections accurately reported during the middle years these data were collected. Finally, the changes in the use of individual sections have not all been upward. Sections 4 and 37 have been used less over this period, and reporting bias is unlikely to account for such decreases in the context of an overall increase in the use of the Act.

1.4.3 Interpretation

If these findings are not simply due to reporting artefacts, what should be made of them? It seems inherently unlikely that changes in population rates of mental illness could explain these findings (Der et al. 1990; Castle et al. 1991). The prevalence of psychiatric disorder would have to have risen dramatically over the relatively short duration of this report, and we were able to use denominator data which suggested that the proportion of all admissions which were formal had increased over the same time frame.

(i) Changes in presentation

The findings could be explained if the clinical picture of psychotic illness has changed. For example there is a widely held, if inadequately explored, belief that patients with psychotic illnesses are more prone to use drugs of abuse now than they were 15 years ago (Cuffel, 1992). Substance misuse might

act to worsen the clinical picture of psychotic illness and lead to associated disinhibition, increasing the likelihood that patients are admitted formally.

(ii) Changes in resources

The changes could also be due to a shift in professional views regarding coercion and safety alongside alterations in the delivery of psychiatric services. Psychiatrists have been criticised for failing to detain patients who have subsequently committed crimes (Ritchie et al. 1994) and are becomingly increasingly preoccupied with risk management (Holloway, 1996). However, the introduction of "Care in the Community" has been accompanied by a massive fall in the number of psychiatric beds (Davidge et al. 1994). Such a reduction in available beds may have a number of consequences relevant to admissions under the MHA. The Mental Health Act Commission, in conjunction with the Sainsbury Centre for Mental Health (1997), shows considerable variation in bed occupancy levels with the majority of wards falling between 90-100% occupancy levels. On 8% of wards studied there were more patients than beds. It seems likely that psychiatrists now reserve admission for patients with the most severe illness, a high proportion of whom are likely to require formal admissions. With pressure on beds, admissions are also likely to be shorter. This means that the same patients may be re-admitted later in the same year. In London, there is concern that such problems are present to a greater degree (Goldberg, 1997). However, this information cannot be obtained from routine data and Glover et al (1990) advise caution in using the mean duration of stay as a measure of bed use since it reflects neither the speed of discharge of short stay patients, nor what proportion of these become long-stay. Without such information this possibility cannot be further explored. It is difficult to separate the competing influences of changes in psychiatric services and the views of mental health professionals - we suspect both are important.

(iii) Changes in the use of individual sections

The fall in Section 4 is probably due to desirable changes in practices. The Mental Health Act Commission and codes of practice recommend that Section 4 is only used in emergencies (Jones, 1996). Because of this advice practitioners may have become more reluctant to use Section 4. Similarly the increase in the number of Section 4 admissions which are converted to Section 3 may indicate its use is being restricted to more severe cases, where there is greater clinical certainty that the patient will require a longer admission.

The rise in Section 3 may also reflect a desirable change in practice. When the Act was first introduced it is likely that patients who had never been placed on a Section 3 were most likely to be

admitted on a Section 2 first. Once a patient is better known to services and has been admitted at least once on a Section 3, the professionals involved will be more likely to (appropriately) use a Section 3 for subsequent episodes of illness.

The fall in the use of Section 37 is less readily explained, as most professionals would agree that transfer of mentally disordered offenders to hospital is desirable. It may reflect changes in the availability of hospital beds. It is possible also that it represents the latest phase of the longstanding decline in the number of mentally impaired people made subject to hospital orders.

The change in Section 48 has been dramatic and may be due to several factors. Firstly, more psychiatrists now visit prisons than did 15 years ago. Most prisons now have sessions from local forensic psychiatrists. Secondly, court diversion schemes may not divert, but they do lead to the identification of psychiatric disorder. As a result mentally ill people now arrive in prison with two things which were not available previously – a description of the offence and a psychiatric history. This makes it easier for prisons to persuade hospitals to accept the prisoner. Thirdly, there is a perceived failure of Sections 35, 36 and 38 to do what the Butler Committee (Home Office and Department of Health and Social Security, 1975) suggested and get mentally disordered offenders out of prison. Despite changes to the use of MHA in this population, there remains substantial evidence of unmet need for psychiatric care in prisons (Singleton et al, 1998).

1.5 Conclusion

Many different forces may act to change the way in which the MHA is used. It is therefore difficult to know what is responsible for the rise in the use of the MHA between 1984 and 1996. It is possible that the steady increase in the use of the MHA is an indicator of some of the opposing pressures impacting on modern psychiatry; the drive towards less hospital, more community based services versus public concerns about the 'threat' posed by the mentally ill. The practice of psychiatry is increasingly influenced by a reluctance to accept risk-taking and uncertainty and a recognition of the need for risk management (Holloway, 1996). The overall result may be a steady increase in the use of coercion, but increasingly fewer resources for this purpose.

Figure 1. Total formal admissions to NHS facilities, private mental nursing homes and special hospitals under the Mental Health Act 1983 and other legislation, by legal status, 1984 - 1997

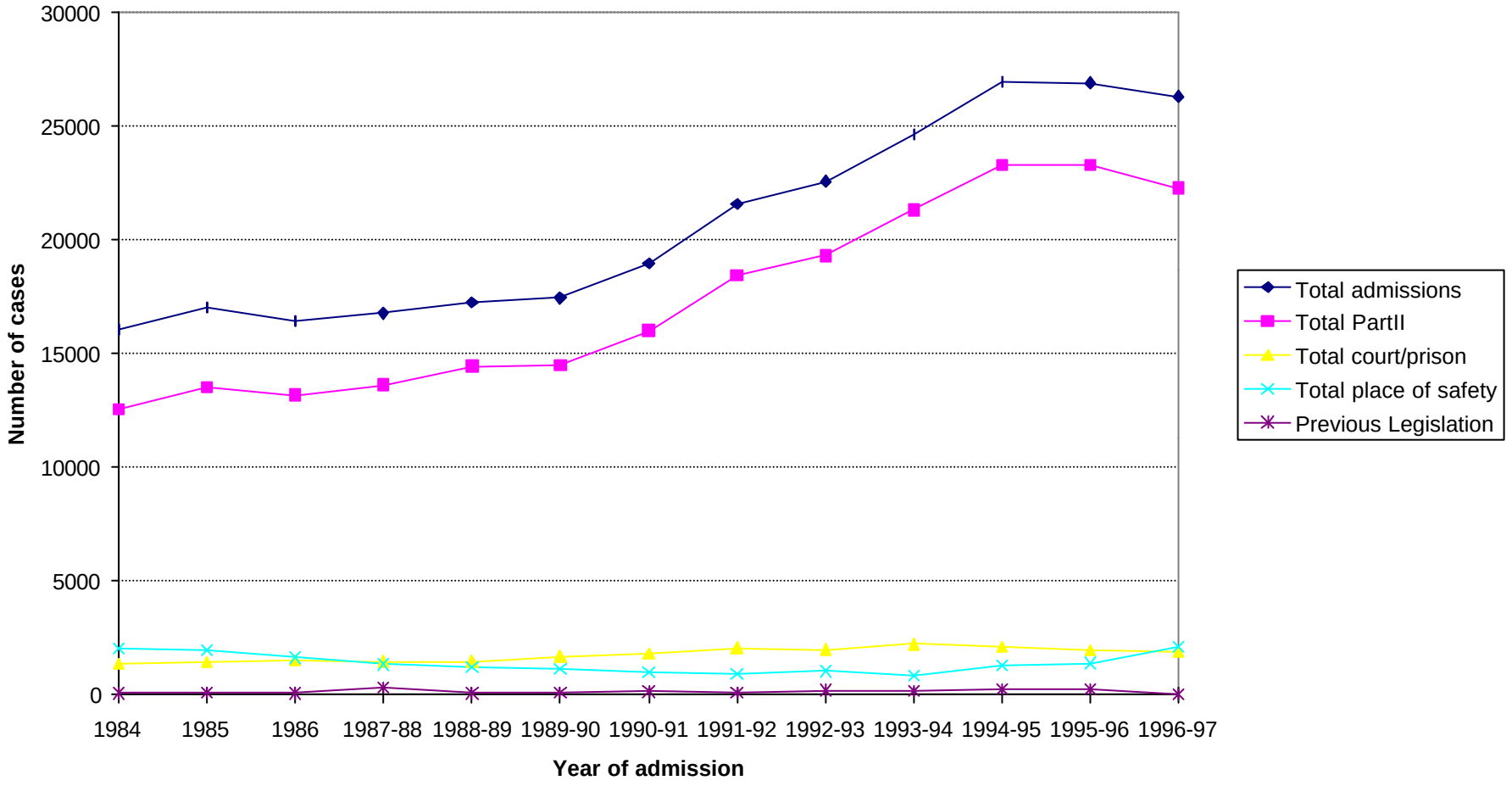


Figure 2. All formal admissions to NHS, private mental nursing homes and special hospitals under Part II - Sections 2, 3 and 4 of the Mental Health Act 1983 (1984-1997)

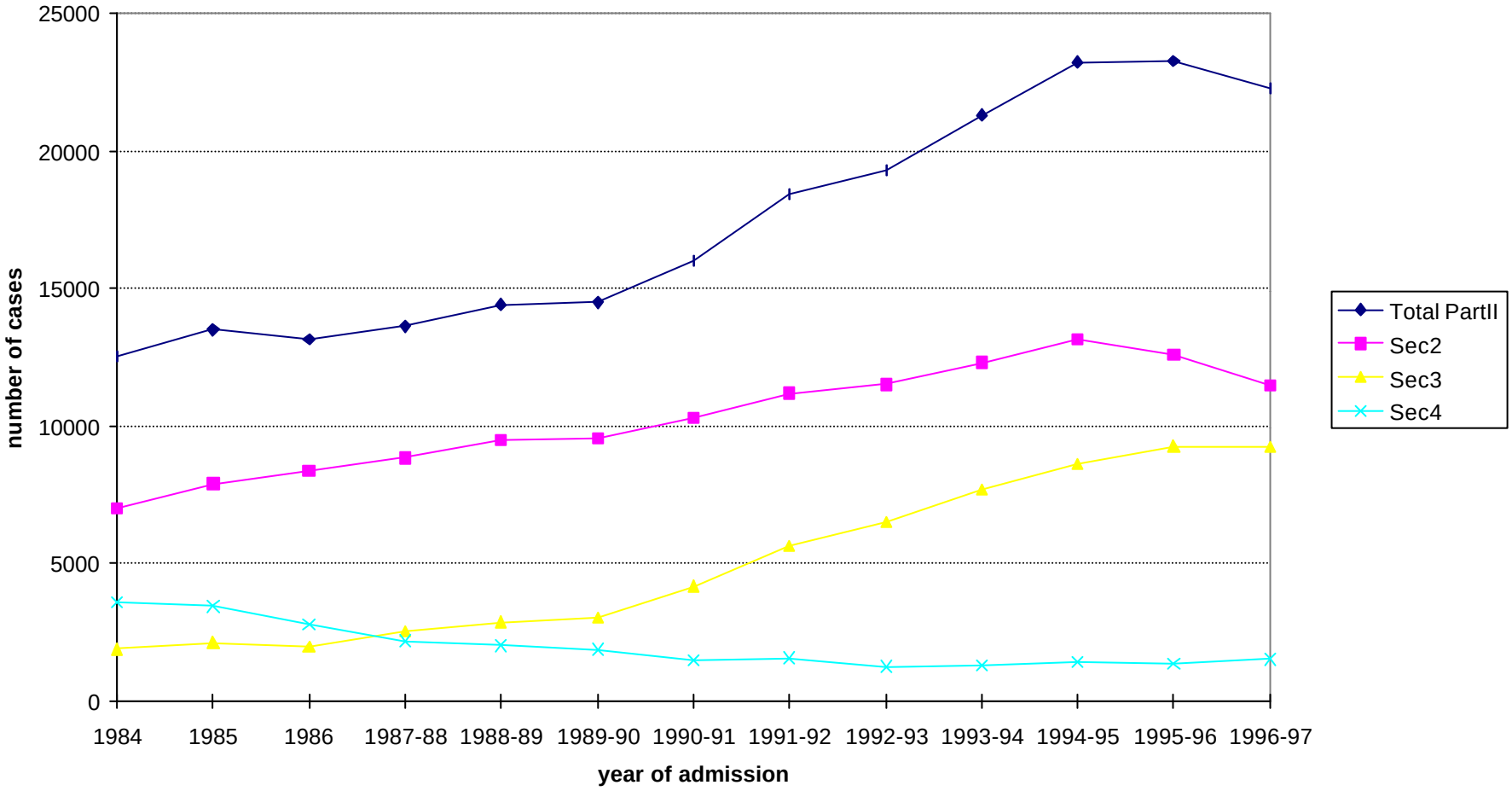


Figure 3. All admissions to NHS, private mental nursing homes and special hospitals under Part III of the Mental Health Act (1984-1997)

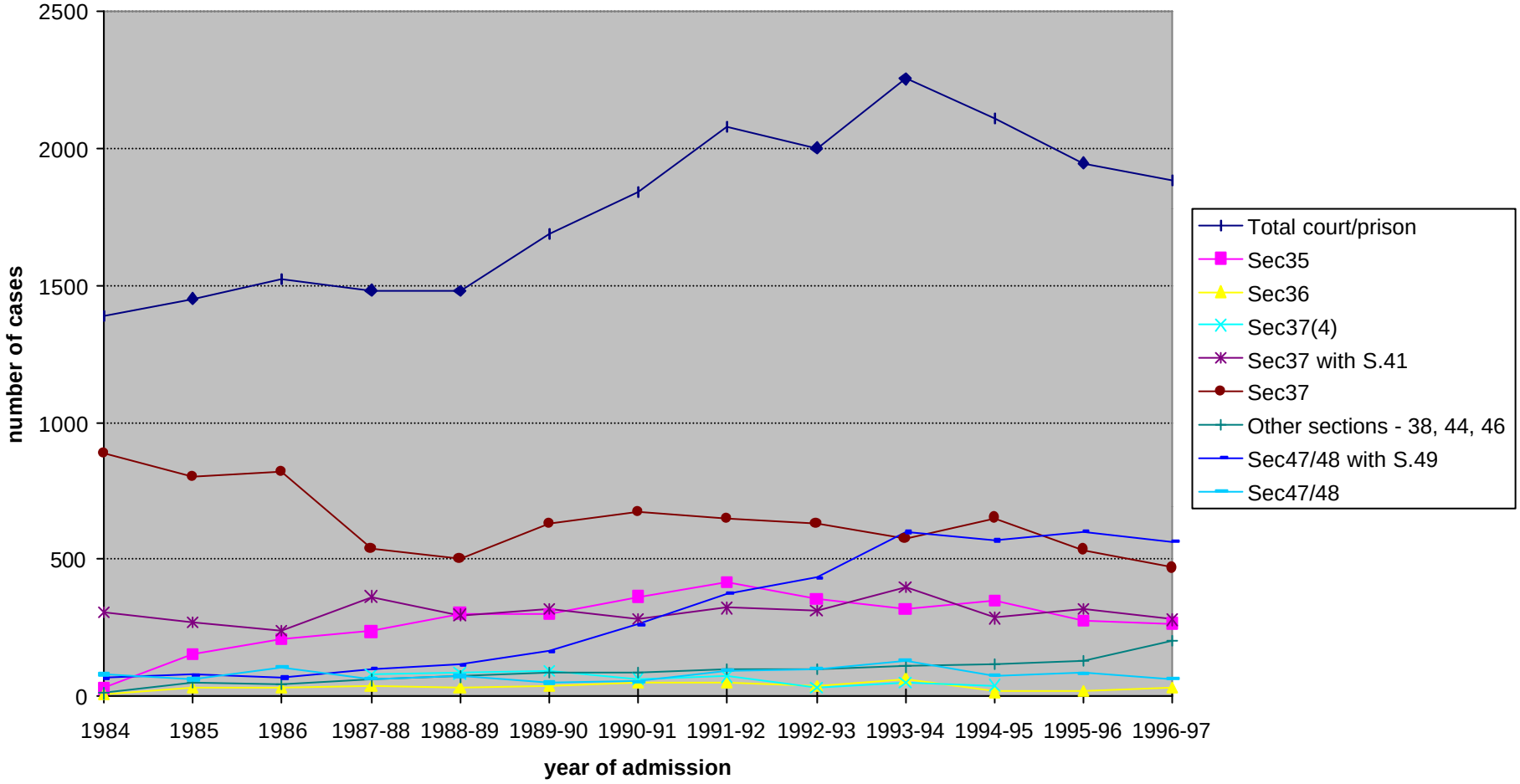


Figure 4. Change in proportion of prison population subject to sections 47 and 48

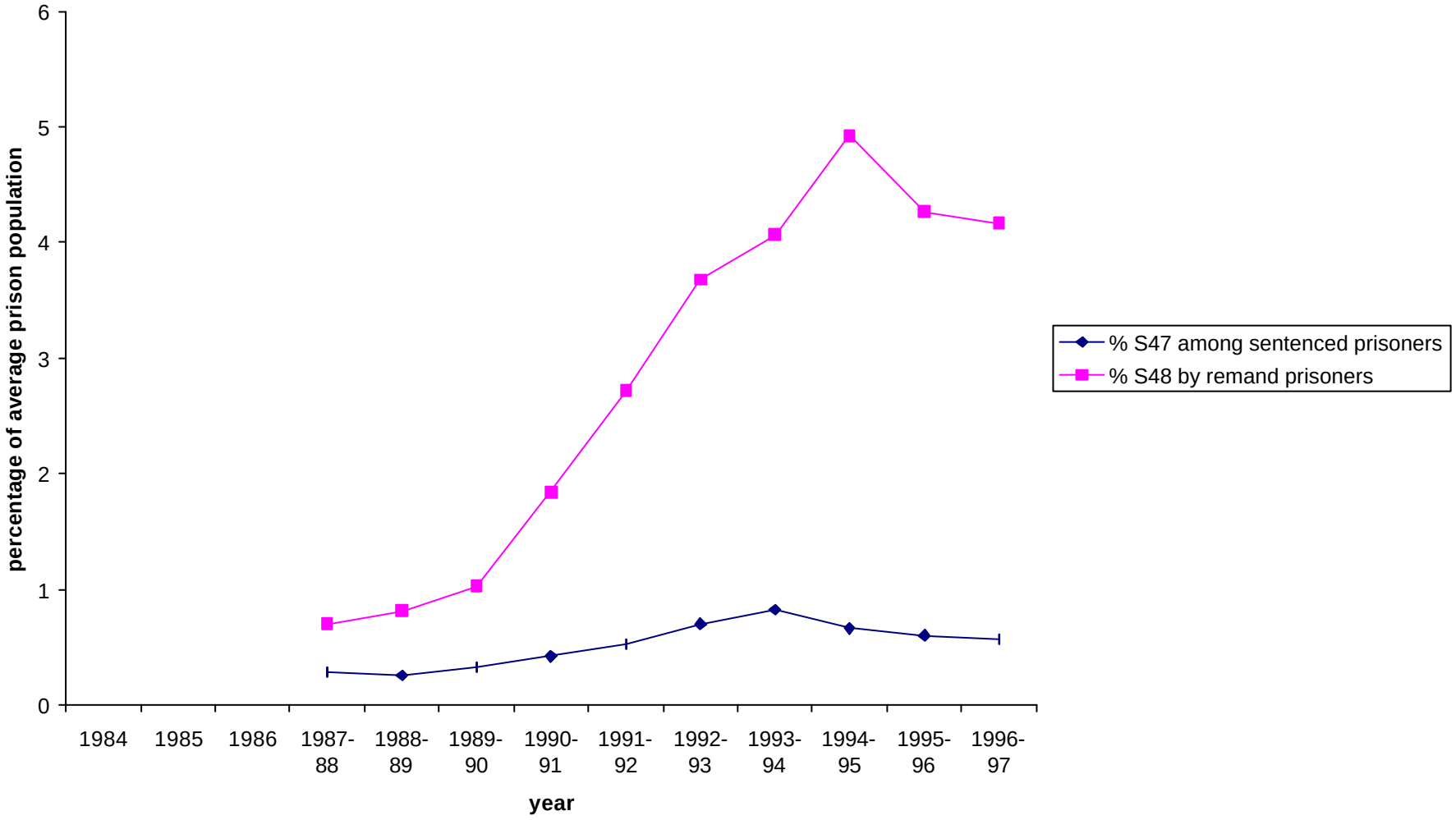


Figure 5. Number of cases changed from informal to Part II of the Mental Health Act 1983 (1987-1996)

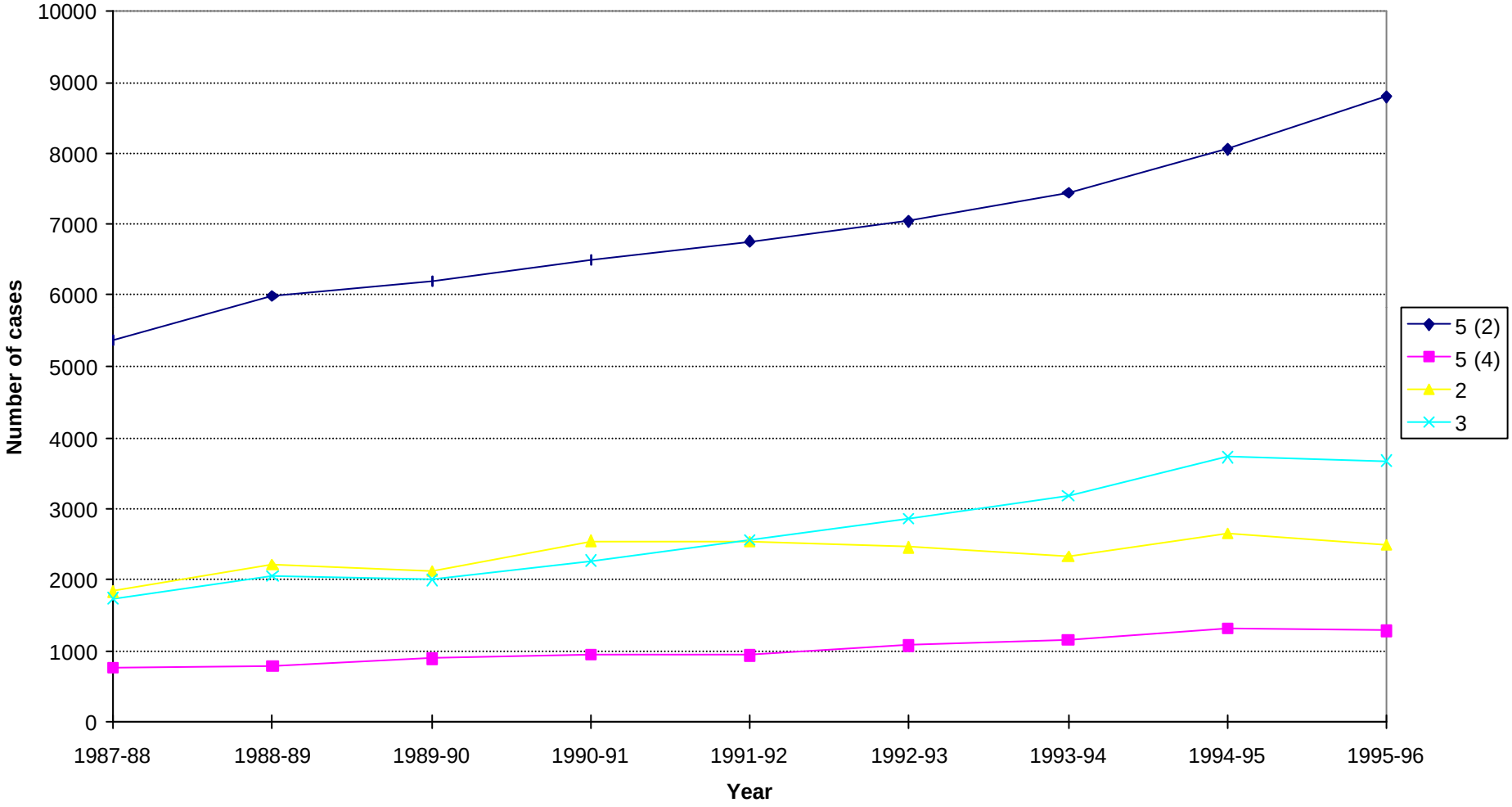


Figure 6. Total number of changes from Section 5 (2) of the Mental Health Act to informal or Part II status

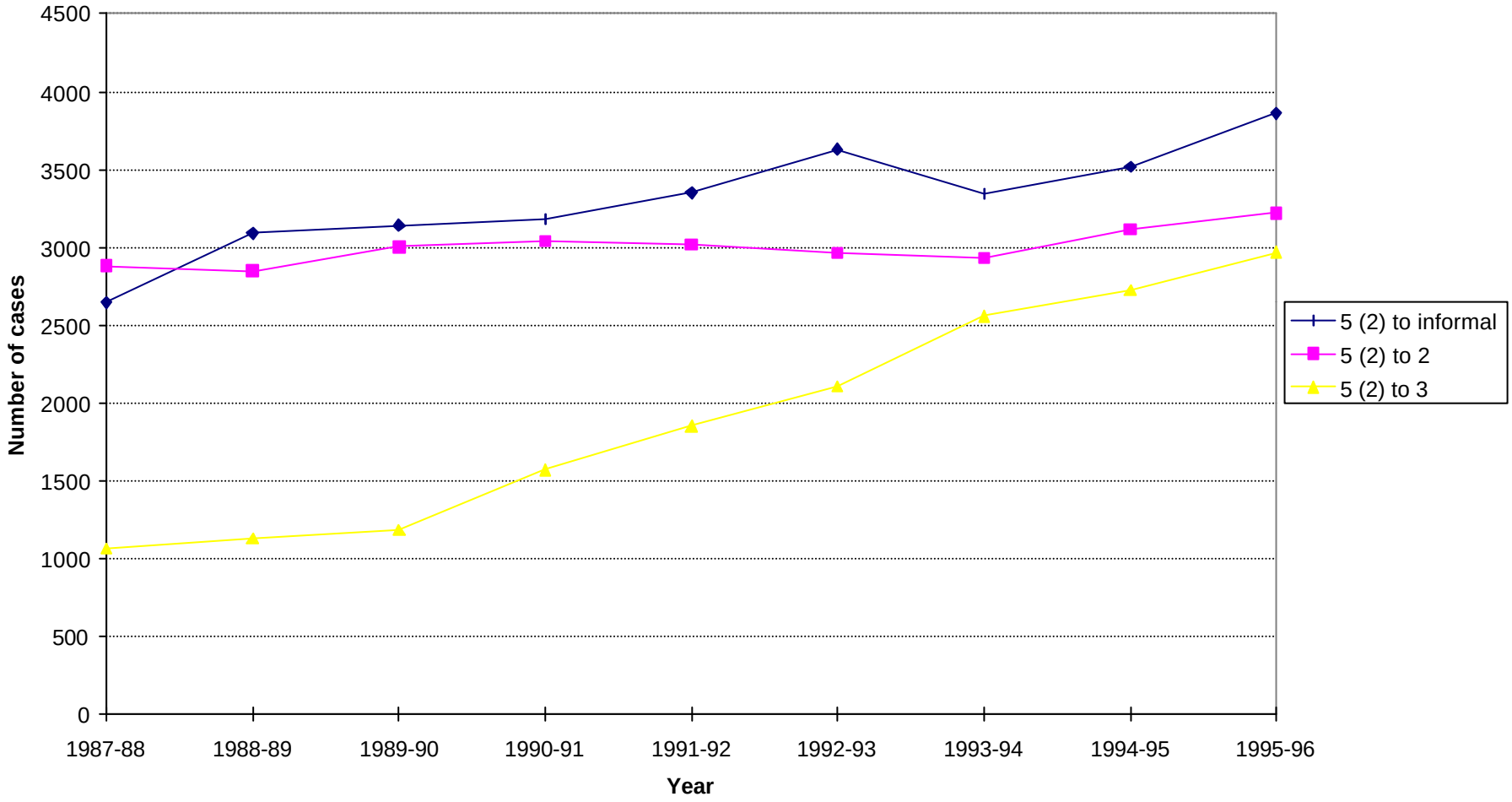
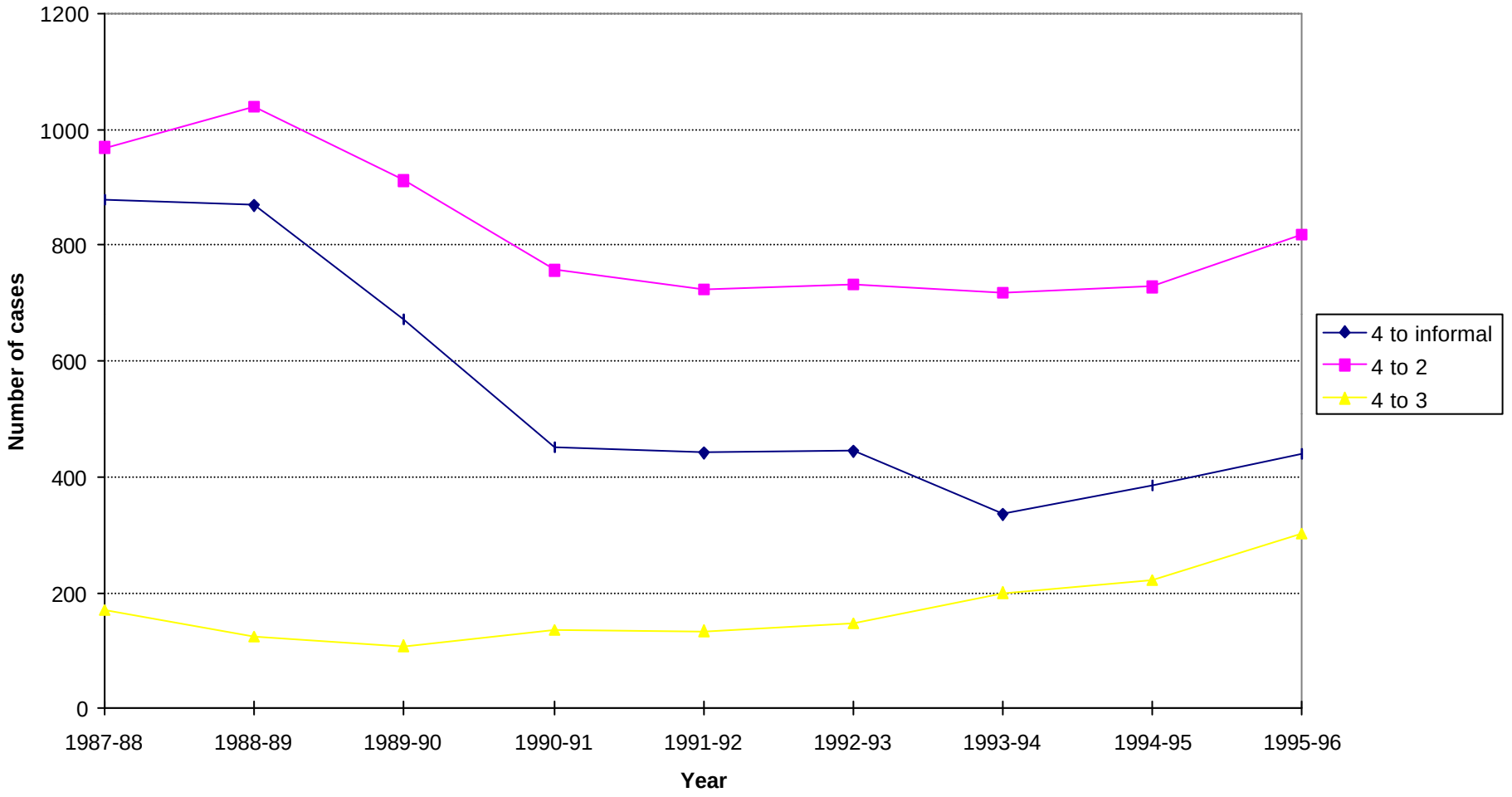


Figure 7. Total number of changes from Section 4 of the Mental Health Act 1983



1.6 References for Part I of the Report

Castle, D., Wessely, S., Der, G. and Murray, R.M. (1991) The incidence of operationally defined schizophrenia in Camberwell, 1965-1984. *Br. J. Psychiatry* 159, 790-794.

Cuffel, B. (1992) Prevalence estimates of substance abuse in schizophrenia and their correlates. *Journal of Nervous and Mental Disease* 180, 589-592.

Davidge, M., Elias, S., Jayes, B., Wood, K. and Yates, J. (1994) Survey of Mental Illness Hostels. Mental Health Task Force.

Department of Health (1998): Inpatients formally detained in hospitals under the Mental Health Act 1983 and other legislation. Prepared by the Government Statistical Service.

Department of Health: Hospital Episodes Statistics system.

Der, G., Gupta, S. and Murray, R.M. (1990) Is schizophrenia disappearing? *Lancet* 335, 513-516.

Goldberg, D. (1997) London's mental health services. *Psychiatric Bulletin*. 21, 65-66

Glover, G., Farmer, R. & Preston, D. (1990): Indicators of hospital bed use. Health Trends, 22: 111-115

Holloway, F. (1996) Community psychiatric care: from libertarianism to coercion. "Moral panic" and mental health policy in Britain. *Health Care Analysis* 4, 235-242.

Home Office and Department of Health and Social Security (1975) *report of the committee on mentally abnormal offenders 1975*, London: HMSO.

Jones, R. (1996) *The Mental Health Act Manual*, 5th edn. London: Sweet and Maxwell.

Mental Health Enquiry (1990): Health and personal social services statistics for England.

Nemitz, T. & Bean, P. (1995): Discrepancies and inaccuracies in statistics for detained patients. Psychiatric Bulletin, 19: 28-32

Ritchie, J.H., Dick, D. and Lingham, R. (1994) *The report of the inquiry into the care and treatment of Christopher Clunis*, London: HMSO.

Singleton, N. Meltzer, H. Gatward, R. Coid, J. Deasy, D. *Psychiatric morbidity among prisoners in England and Wales* London: The Stationary Office.

The Mental Health Act Commission and Sainsbury Centre for Mental Health. (1997). *A one-day visit to 309 acute psychiatric wards by the Mental Health Act Commission in collaboration with the Sainsbury Centre for Mental Health.*

Wall, S., Hotopf, M., Wessely, S. and Churchill, R., (1998) More formal admissions into fewer psychiatric beds. BMJ (In press).

Wall, S., Buchanan, A., Fahy, T., Hotopf, M., Wessely, S. and Churchill, R. (1999) A systematic review of data pertaining to the Mental Health Act (1983). *Department of Health* (In press).

Part 2: Chapter 1 – The systematic review

2.1.1 Introduction

In recognition of the need to decide future legislative and research priorities using the existing knowledge base, the Department of Health (DH) commissioned the old King's College School of Medicine and the Institute of Psychiatry to conduct a systematic review of all data pertaining to the Act. Part 2 of this report describes the methods used and results of this piece of work.

Since 1983, the use of, and procedures associated with the Mental Health Act (MHA) have been much debated. A substantial quantity of research relating to the application of the Act has been conducted. Since the Act is a piece of legislation and should involve applying a set of rules, there ought to be limited scope for interpretation. However, a number of concerns have been raised about variations in practice associated with a number of factors such as the socio-demographic characteristics of patients. It is important to establish how this legislation is being applied, whether it is implemented appropriately, how different parts of the Act are being used and whether genuine variations exist in how different parts of the Act are being applied over time and in different groups of patients.

The overall objective of this review was to provide a thorough and systematic evaluation of all data pertaining to the MHA. Such a study is of considerable importance to policy advisors within the Department of Health, serving to inform future policy decisions relating to the reconsideration of the Act. The review was intended to provide an objective summary of the data pertaining to the Act as a whole and its different parts, identifying specific aspects of the Act which appear to work effectively and highlighting aspects which appeared problematic or ineffective.

2.1.2 Aims

By identifying and appraising all available data, it was intended that a range of specific themes relating to the Act would be examined. These were:

1. Secular trends in the use of the Act to establish whether there has been a change in patterns of usage.
2. Variations in practice and deviations from the Act, for example, according to ethnic group, geographic location and other demographic variables (age/sex/education).
3. The outcomes of various aspects of Act.
4. The use of appeals and different types of appeal.
5. The actual use of treatment/discharge plans.
6. The actual use of consent forms.

2.1.3 Method

In order to fulfil the aims of the review, all data (both published and unpublished) pertaining to the use of the Mental Health Act 1983 had to be identified. The methods chosen for this review were intended to minimise the risk of bias in the identification and selection of relevant literature and involved conducting a thorough and comprehensive search involving DH databases, routinely collected hospital and Trust data and general audit where available. Electronic databases such as Medline, PsycLit and Embase were also used to identify published articles and books and specialist journals were handsearched.

(i) Criteria for inclusion in the review

Reports were eligible for inclusion if they incorporated data that was relevant to the MHA. Articles reporting the opinions of clinicians and other users of the Act and those relating to civil liberty issues were not eligible for inclusion. Legal articles and law reports were also not included. Three other projects, commissioned by the DH, are currently underway and when complete will provide a comprehensive picture of the use and development of the MHA. The information and relevant parts of the Act covered by these projects are also not reviewed here. These are:

- The PriSM Evaluation of Supervised Discharge and Guardianship
- Royal College of Psychiatrists investigation of current use of Part II of the MHA
- The HACRU evaluation of Mental Health Review Tribunals

See Appendix F for details

(ii) Search strategy to be used in the review

Articles pertaining to the Act were identified using a variety of different methods.

1. Keyword search of Medline, PsycLit, Embase, BIDS, HealthSTAR was conducted in October 1997. Keywords used were ‘Mental Health Act’, ‘the Act’, ‘MHA’ and ‘mental health legislation’. This search was updated in June 1998. Appendix A provides a list of all the journals identified as a result of this search. Although the keyword search may not appear comprehensive, the main inclusion criteria for this review is that any studies mention the MHA, otherwise they were excluded.
2. Other journals not indexed on the above databases (such as Psychiatric Bulletin and Social Work Today) were handsearched from 1983 onwards. Appendix B gives a list of the journals identified.

These were identified using the King's Fund, Institute of Psychiatry and King's College School of Medicine and Dentistry library lists. Any such journals identified were duly handsearched from 1983 to June 1998.

3. A cross-reference check of papers collected was performed which yielded further papers and journal sources and these were followed up with further hand-searching.
4. Organisations involved in mental health care were contacted directly for their own publications and/or any further information on primary data relating to the MHA (Appendix C).
5. Organisations such as the King's Fund, the College of Health, the Mental Welfare Commission were contacted for grey literature (eg brochures, leaflets), press-cuttings and own publication. Healthline was used to identify any lesser known organisations of relevance (Appendix C).
6. The Institute of Mental Health Law web page was searched for further information.
7. Experts were contacted and letters were published in the British Journal of Psychiatry and the Psychiatric Bulletin asking for any unpublished data.
8. For additional data not included in Part 1 of this report, DH databases were accessed to obtain data that is collected and stored by the Department of Health and the Government Statistical Service. For example, a *Statistical Bulletin* published in 1996, contains information on patients detained in NHS hospitals, private mental nursing homes and special hospitals under the Mental Health Act. This booklet contains analyses at countrywide as well as commentary on trends and graphical presentations of data. In addition, the Government Statistical Service produces a more detailed booklet *Inpatients formally detained in hospitals under the Mental Health Act 1983 and other legislation* which contains similar information along with analyses by Regional Office areas, Regional Health Authority areas and District Health Authority area as well as tables showing the raw data provided by the Trusts and Directly Managed Units. The Home Office also publish annually *Statistics of Mentally Disordered Offenders, England and Wales* which presents statistics on offenders who were detained in, or discharged from, hospital and were subject to restrictions on discharge under Part III of the Mental Health Act 1983.
9. Through links with the DH, attempts were made to identify other routinely collected hospital data and general audit data.
10. Books and reports of relevance to the Act were also searched to identify data not published as journal articles.

(iii) Data extraction

The reference manager package Procite was used to manage identified references and collating data contained. All initial information was extracted using this reference management package. Further data

including the methodology used, the section of the act targeted, the subject numbers and any other information that could be summarised in table format was extracted using Excel. A random peer-review was carried out to ensure agreement about the information extracted (n = 156).

2.1.4 Results

A total of 171 journals and 708 papers were identified through the above methods. Applying the inclusion criteria, 560 articles were excluded because they contained no data. Fifty articles have been referred to within the report and the remaining 148 articles related to the Act as follows:

Table 1.1 Papers included in the review and area to which they relate

Area covered	**Number of articles**
The Mental Health Act (MHA) as a whole	20
Part II of the MHA	46
Part III of the MHA	23
Part X of the MHA	29
Miscellaneous topics as follows:	
(i) The use of ECT under the MHA	4
(ii) Violence and the MHA	3
(iii) Aftercare in the MHA	2
(iv) Care of the elderly	5
(v) Forensic settings	6
(vi) Mental impairment	2
(vii) Adolescent unit	1
(viii) Interdisciplinary use of the MHA	6
(ix) Training in the use of the MHA	1
Total	

In addressing the aims of this review, we identified a large number of articles providing information on variations in practice and deviations from the Act according to ethnic group, geographic location and other demographic variables, and outcomes of various aspects of the Act. Relatively little information was available on the use of appeals and different types of appeal, the use of treatment/discharge plans and the use of consent forms.

2.1.5 Organisation of Part 2 of this report

Part 2 of this report is divided into six chapters. This chapter contains only the introduction to the systematic review, the methods used and the overall results of this review. The remaining five chapters relate to specific Parts of the Act, with references and appendices as follows:

- Chapter 2 reviews literature pertaining to the Act as a whole.
- Chapter 3 reviews papers relating to Part II of the Act.
- Chapter 4 reviews papers relating to Part III of the Act.
- Chapter 5 reviews papers relating to Part X of the Act.
- Chapter 6 reviews miscellaneous papers on specific topics.
- References.
- Appendices.

Part 2: Chapter 2 – Use of the MHA as a Whole

2.2.1 Introduction

This chapter assesses the use of the Mental Health Act (MHA) as a whole. It is centred around three key questions which have been addressed in the literature. These questions are:

1. How often is the MHA used?
2. What are the characteristics of patients detained under the MHA?
3. What are the outcomes of use of the MHA?

The emphasis of this chapter is on studies that have defined whole populations of patients in contact with general psychiatric services and assessed their experiences of being admitted under the Mental Health Act.

2.2.2 Results

Of the 148 relevant articles identified, 20 are discussed in this chapter, summarised in table 2.1. The majority are cross-sectional studies which define populations of patients using psychiatric services, and compare those admitted formally with those admitted voluntarily. Many of these studies describe relatively deprived urban populations.

(i) How often is the MHA used?

This question has already been addressed to a large extent in the first part of this report. We found that formal admissions accounted for approximately 12% of all psychiatric admissions. However, crude figures disguise the experience of many patients with chronic or relapsing and remitting illness who are admitted much more frequently.

In a detailed case note study Soothill et al (1990) estimated that 20% of all admissions in a Birmingham catchment area were formal. A one-day nationwide visit by the MHAC (1997) found that 32% of all patients admitted were detained under the Act. Ellis and Lewis (1997) presented a case series of 630 emergency psychiatric presentations occurring over a three month period to a North London hospital. 18% of all psychiatric presentations to the Accident and Emergency Department led to psychiatric hospitalisations, and 10% of these (or 2% of the total presentations) were formal admissions – a figure which is close to that found in Part I of this report.

Among patients known to general adult psychiatric services the picture is very different. Davies et al (1996) defined a population of patients with psychiatric illnesses known to two catchment area psychiatric teams and found that 52% of patients with psychosis had a past history of detention under the MHA. Johnson et al (1998) found that among over 500 patients with psychosis, 79% had been admitted under the MHA at least once in the course of their illness. The same study found over the course of a follow up period (3.2 years), 20% of this population had been admitted at least once under the MHA. These studies indicate that – in urban populations at least – most patients with psychotic illness will be formally admitted at some point in the course of their illness.

Only one paper we identified assessed secular trends in the use of the MHA (Patrick et al, 1989). This paper – which studied an inner city catchment area - showed an increase in the proportion of formal admissions rising from 28% to 44% over a three year period (1986-1988). This accords with the findings of the first part of this report.

One paper assessed the frequency that requests to social workers for MHA assessments led to the patient being detained (Hatfield et al, 1997). They found that 63% of assessments led to the patient being sectioned, and that a higher proportion of patients were sectioned (81%) when the request came from a psychiatrist.

In summary, the Act is being used more frequently, and - for urban centres at least - most patients with psychotic illness are likely to experience being detained under the MHA at some point in their illness.

Table 2.1: Use of the MHA as a whole

Author and Year	Background	Main findings
Banerjee, S., Bingley, W. & Murphy, E 1995	A prospective descriptive study of all deaths resulting in an inquest in England and Wales of patients detained under the Act, and who died while liable to be detained, between 1st April 1992 and 31st March 1994. The aim was to investigate the characteristics of the deaths of patients detained under the Act.	At time of death: • Male 59%. • 28% aged 15-29yrs. • 76% white european. • 60% were under S3 of the Act. • 78% in general psychiatric units. • 43% diagnosed as schizophrenic. Cause of death: • 46% probable suicide. • 33% natural causes. • More men committed suicide (68%), died of natural causes (76%), iatrogenic (53%), and accidental suicide (77%) than did women. • More white european committed suicide (79%), died of natural causes (93%), iatrogenic (96%), and accidental suicide (92%) than did black asian or black afro-carribean. • Suicides occurred more often on leave or during absconsion. Other deaths occurred most often in hospital. • The majority of those who committed suicide out of hospital grounds did so on the day they left. • S3 was the most common section of all detainees whatever the cause of death. • Policy change was affected after 60% of accidental deaths, 43% of suicides, 36% of iatrogenic deaths and 16% of natural deaths when compared to no policy change at all.
Bebbington, P.E., Feeney, S.T., Flannigan, C.B., Glover, G.R., Lewis, S.W. & Wing, J.K. 1994	This study is the 2nd of 3 papers reporting the results of a comparative audit of acute admissions to hospital from 2 inner London districts. The main purpose was to provide an analysis of the reasons for the higher rates of admission, and of compulsory admission, among black Caribbeans compared with whites. Information was collected on all patients who were on the wards on a single day and all who were admitted during the following 91 days. Patients admitted under Parts II, X and III are included.	Compulsory admissions: • Male 54.4%. • 56% of compulsory admissions were detained out of hours. • 35% of the black population and 17% of the white population were admitted compulsorily • 10% of blacks and 3% of whites were admitted under an emergency section. • 17% of compulsory & 19% informal admissions were 1st admissions. • 84.5% of compulsory admissions were emergency compared to 84% of informal. • 72.8% compulsory admissions had psychosis compared to 41.4% of informal admissions. • 22% of compulsory admissions had affective disorder compared to 45% of informal admissions.

Table 2.1 (continued): Use of the MHA as a whole

Author and Year	Background	Main findings
Bindman, J. & Reid, Y. 1998	Unpublished data. Consecutive psychiatric admissions from April to December 1997 were interviewed (n=100) using an adaptation of the Mac Arthur Coercion study interview. The aim was to adapt and replicate the study in a UK sample, establish the associations of perceived coercion, and relate perceived coercion to engagement with community treatment over a 9 month follow-up period. 19 patients were detained at the time of admission and a further 13 were detained before they were interviewed.	• 55% of sample were male. • Detained patients were more likely to perceive high coercion (83% compared to 34% of voluntary patients). • 64% of non-white patients experienced high coercion compared with 41% of white patients, but there were no significant differences for subgroups according to ethnic origin (i.e. Detention). • Those feeling highly coerced were more likely to have been admitted with police involvement (33% vs. 16%) or to have had a MHA assessment at home (25% vs. 2%).
Davies, S., Thornicroft, G., Leese, M., Higgingbotham, A. & Phelan, M. 1996	A one year study of the prevalence of psychosis and the risk of detention under the Act in two psychiatric hospitals in South London 439 cases were identified and examined using case notes and MHA forms. Sections 5(2), 5(4), 2, 3, 4, 135, 136, 35, 37, 37/41 are included.	• Previous detention under the Act was 42.5% for whites; 70.4% Black Caribbean; 69% Black African; 46.7% other ethnic groups. • The relative risk related to previous detention under the Act was 1.67 for Black Caribbeans and 1.62 for Black Africans. Both statistically significant. Detained under: • S2: 6.6% white; 13.9% black; 20% other. • S3: 6.6% white; 14.6% black; 12.5% other. • S37: 1.6% white; 0.7% black. • S37/41: 1.2% white; 2.1% black. • S4: 1.2% white; 2.1% black. • S5.2: 2.3% white; 4.1% black. • S135: 0% white; 0.7% black. • S136: 1.2% white; 6.3% black. • 44.5% of the psychotic disorders identified were of schizophrenia. • 51.5% had been placed under Section at some time in their life.

Table 2.1 (continued): Use of the MHA as a whole

Author and Year	Background	Main findings
Ellis, D. & Lewis, S. 1997	Aim was to identify patterns of presentation and to obtain an impression of what happens to people presenting with psychiatric problems to an inner-city A&E department. 630 data collection forms were completed over 3 months.	• 18% were admitted to a psychiatric ward. • Of those, less than 10% were detained under the Act. • In-hours presentations were significantly more likely to be referred to a psychiatrist or admitted to a psychiatric ward.
Feehan, C.J. 1994	A two year audit of a psychogeriatric hospital was undertaken using the Section papers of all 35 patients detained to compare previously shown high use of S5.2 and to assess the use of the Act in detaining cognitively impaired patients against their wishes. Sections 2, 3, 5.2 and 58 are examined.	• 28.6% of sample male. • 5% (35) of whole population were detained. • 77.8% detained under S2; 22.2% detained under S3. • One patient was detained under S5.2 and was changed to S2. • No relatives appealed on the patients behalf. • One patient appealed against S3 but withdrew. • One patient appealed against S2 but failed. • Most common reason for detention was for treatment for self-neglect: underlying reasons for this were depression (11), dementia (12) and psychosis (8).
Hatfield, B., Huxley, P., & Mohamad, H. 1997	A continuous monitoring exercise in 5 Local Authorities provided a profile of all individuals coming into the Act's orbit. 4401 incidents of ASW assessment for compulsory detention took place. A total of 2779 compulsory detentions (63% of those assessed) were implemented.	• Both men and women were more likely to be living alone. • Men more likely to be living with parents and women with partners or children. • 58% were described as suffering from a psychotic illness. • Men were more likely to have schizophrenia. • Women were more likely to have affective psychosis. • Women were considerably more likely to have depression than men. • 61% of men with schizophrenia were under 40yrs. • 64% of women with depression were over 40yrs. • Over 4 yrs there was a 47% increase in assessments involving men with schizophrenia. • 63% of all ASW assessments resulted in an application being made. • This rises to 81% if the case is referred by a psychiatrist. • Following psychiatric assessment; a further 9% are admitted to hospital informally. • People referred by psychiatrists but not detained following ASW assessment were significantly less likely to be suffering from psychotic illness than those detained.

Table 2.1 (continued): Use of the MHA as a whole

Author and Year	Background	Main findings
Johnson, S., Wright, S., Bindman, J., Szmuckler, G., Bebbington, P., Kuipers, E. & Thornicroft, G. – personal communication	Unpublished data kindly provided. Data form part of the results of a survey of patients attitudes toward their detention under the Act. Those questioned had 2 or more admissions or one or more contacts with mental health services between January and June 1994. No information regarding study size or location	• 79% had previously been sectioned. • 67% of whites, 100% of 2nd generation blacks & 83% of 1st generation blacks previously sectioned. • 32% of 1st gen. black; 25% of 2nd gen. Black; 10% white moderately/very angry about their section. • 26% of 1st gen. black; 31% of 2nd gen. Black; 17% white moderately/very upset about their section. • 24% white; 63% 2nd gen. Black; 26% 1st gen. Black felt section was definitely/probably wrong. • 37% white; 67% 2nd gen. Black; 26% 1st gen. Black have less trust since their section.
Johnson, S., Leese, M., Brooks, L., Clarkson, P., Guite, H., Thornicroft, G., Holloway, F. & Wykes, T. 1998	The PRiSM Psychosis Study, one of whose aims was to establish the effect of detention under the Act. 286 patients were included.	• Over a mean follow-up period of 3.2 years, 20% of patients had at least one admission under the Act. Of the 105 patients who had psychiatric inpatient admission between case identification and follow-up: • 53% had been detained under the Act. • 43% detained once; 46% between 2 and 4 times; 11% between 5 and 7 times. • 19% responders and 21% of non-responders had been detained. Significant differences between ethnic groups in rates of detention: • 15% whites detained; 33% black Caribbean; 27% black African; 21% other.
Leavey, G., King, M., Cole, E. Hoar, A. & Johnson Sabine, E. 1997	The aim of the study was to assess patients and relatives satisfaction with psychiatric care after a first episode of psychosis. 93 patients were recruited from a North London catchment area over a 12 month period (1991-92). 59 completed the questionnaire	Patients satisfied: • Information and advice: detained 28.8%; informal 54.2%. • Humane Aspects: detained 28.8%; informal 50.8%. • Hotel Aspects: detained 28.8%; informal 49.2%. • Helpfulness of psychiatric care: detained 28.8%; informal 50.8%. Relatives satisfied: • Information and advice: detained 30.5%; informal 55.9%. • Humane Aspects: detained 32.2%; informal 55.9%. • Hotel Aspects: detained 28.8%; informal 44.1%. • Helpfulness of psychiatric care: detained 32.2%; informal 42.4%.

Table 2.1 (continued): Use of the MHA as a whole

Author and Year	Background	Main findings
McKenzie, K., van Os, J., Fahy, T.A., Jones, P., Harvey, I., Toone, B. & Murray, R. 1995	A survey of all admissions to two South London psychiatric hospitals aged 16-60 years with presence of delusions, hallucinations or formal thought disorder, was carried out between 1986 and 1989. The aim was to compare course and outcome of psychotic illness in a group of afro-Caribbean and white patients.	• Afro-Caribbean group were significantly more likely to be admitted formally over the follow-up period (82.3% compared to 43.2% of whites). • Adjusting and accounting for other variables revealed that the afro-Caribbean population have a poorer prognosis with regard to outcomes such as the use of Sections of the Act and time spent in jail.
Moodley, P. & Thornicroft, G. 1988	Study aimed to establish whether there was good evidence to support the commonly expressed stereotype of formal patients in inner cities. 100 patients detained under Sections 2, 3, 4 and 5(2) case notes and section papers were examined	• 26% West Indian, 65% white, 9% other. • Medication administered upon admission: 28% white, 38% black. • Intramuscular medication given without consent: 12% white; 19% black. Reasons for detention: • Violence: 92% black men; 53% white men; 46% black women; 36% white women. • Deliberate self-harm: 66% white men; 23% black men. • 38% white and 12% black were employed. • 48% white women were married. • 21% white women; 69% black women; 44% white men; 0% black men were living alone. • 36% black and 0% white presented by police. • Other psychosis applied to 65% black and 26% white. • Detained in locked ward at time of section: 100% black men; 56% white men; 58% white women; 31% black women.
Patrick, M., Higgit, A., Holloway, F. & Silverman, M. 1989	A survey of 131 inpatient psychiatric beds carried out over two years (1986 and 1988) aimed to assess the characteristics of the patients and their needs.	• Formal admissions were 28% in 1986 and 42% in 1988. • 57.7% of blacks and 29.4% of whites were formally detained in 1988. Age group and ethnic differences of detained patients: • 16-39 years: black 46%; white 14.7%. • 40-64 years: black 7.7%; white 8.8%. • 65 years +: black 3.8%; white 5.9%. • In 1988, only one detained patient was not psychotic.
Powell, G., Caan, W. & Crowe, M. 1994	Audit of all inpatients, day patients and outpatients in three hospitals within a South London HA were collected over 13 months (1990-91). 275 patients involved in 1000 incidents of violent behaviour were identified. The aim was to determine whether it is possible to identify events preceding incidents of violence.	• Decisions about the MHA or wards of court was an antecedent for less than 1% of incidents. • Individuals responsible for 10 or more incidents were more likely to have been detained under the Act (90.5%) than individuals who committed only one assault (42.7%). • There was a significant preponderance of detained patients, most marked in female population: 91% of frequent assailants were detained compared to 29% of single assailants.
Rusius, C.W. 1992	A questionnaire was designed to ascertain the views of 50 psychiatric outpatient attenders who had been detained	Feelings about being forced to stay in hospital against will: • 66% grateful, 24% not bothered, 10% resentful.

	under the Act within the past three years. The aim was to assess patients retrospective views of being detained and treated against their will.	Of the 95% forced to take drugs against their will: • 60% grateful, 25% not bothered, 15% resentful. Of the 44% who felt they had been given ECT against their will: • 54% grateful, 14% not bothered, 32% resentful.

Table 2.1 (continued): Use of the MHA as a whole

Author and Year	Background	Main findings
Singh, S.P. 1998	A questionnaire survey of medical officers responsible for admissions to 6 acute wards in Nottingham was conducted to test the hypothesis that 'perceived ethnicity' of a patient has no independent effect on the risk of compulsory admission. The sample included all consecutive admissions between 1/2/95 and 31/7/95 (n=417).	• 21.82% admitted formally Of the whole sample: • 81.5% white european; 7.3% black-carribean; 0.4% black African; 1.7% Pakistani; 2.5% Indian; 0.2% Bangladeshi; 0.2% Chinese; 2.75% mixed ethnic origin • 95.7% of white; 79.5% of black-Carribean and 28.6% of Asian were British born • Asians were significantly more likely than whites to be young men, but not more likely to be detained • No significant difference between Asian and black-Carribean groups on any of the variables • Black-Carribean constituted 22.4% of all compulsory admissions • 43.2% of Black-Carribean admissions were compulsory compared to 18.8% for whites • 81.8% of B/C and 56% of whites were diagnosed as psychotic • B/C were significantly younger • A higher proportion of B/C under 35 yrs of age were detained • B/C were significantly younger, more likely to be diagnosed psychotic, more at risk of violence, and more likely to be detained than their white counterparts
Soothill, K., Kupituksa, P., Badiani, D. & Macmillan, F. 1990	The aim of this study was to consider national and international variations and international differences when considering the types of patients being currently compulsorily detained or admitted under the Act. 103 patients in England and 30 in Thailand case notes were examined retrospectively.	• England: 7% admissions were compulsory (DH 1986 figures). • Birmingham: 20% admissions were compulsory. • Thailand: 40% of admissions estimated as compulsory (no legal definition exists). Sections used: • Birmingham: S2 73.6%; S3 11.3%; S4 7.5%; S37 5.7%; S48 1.8%. • Lancaster: S2 68%; S3 8%; S4 18%; S37 6%. Source of admission: • Birmingham: home 57%; public place 2%. • Lancaster: home 54%; public place 2%. • Thailand: home 97%; public place 3%. Previous psychiatric treatment: • Birmingham 87%; Lancaster 72%; Thailand 67%. Length of stay: • Majority of cases in all three localities stayed less than 3 months. Diagnosis: • Schizophrenia: Birmingham 37%; Lancaster 36%; Thailand 93%. • Organic psychosis: Birmingham 8%; Lancaster 2%; Thailand 3%. • Personality disturbance: Birmingham 6%; Lancaster 18%. • Paranoid psychosis: Birmingham 6%; Lancaster 12%. Alcohol problems:

		• Chronic alcoholic: Birmingham 8%; Lancaster 2%; Thailand 0%. • Repeated drinker: Birmingham 13%; Lancaster 18%; Thailand 20%. • No serious problem or no specific information: Birmingham 79%; Lancaster 80%; Thailand 80%. Aftercare: • Birmingham: 64% outpatients. • Lancaster: 36% CPN; 38% outpatients. • Thailand: Geographical problems cause difficulties even distributing medication – therefore little outpatient care.

Table 2.1 (continued): Use of the MHA as a whole

Author and Year	Background	Main findings
The MHAC and the Sainsbury Centre for Mental Health 1997	A one-day visit to 309 mental health wards in 118 NHS Trusts in England was carried out unannounced. The aim was to collect information on 1) the number, qualifications and deployment of staff, 2) the adequacy and understanding of policy and procedures about leave for detained patients, and 3) the safety and privacy of women patients	• 32% of the total admissions were detained under the Act • A total of 32 detained patients were AWOL • In all but one of the above cases, staff were aware and following appropriate procedures • Only 30% of all wards had patient leave policies dated after the publication of the Mental Health (Patients in the Community) Act 1995
Thomas, C.S., Stone, K., Osborn, M., Thomas, P.F. & Fisher, M. 1993	The records of all acute psychiatric admissions in a Central Manchester HA from 1984-87 were examined (n=1534). The aim of the study was to describe the rate of psychiatric admissions, modes of referral, rates of compulsory detention and psychiatric diagnosis among three ethnic groups.	Groups are divided into UK (Europeans born in England); AC1 (1st generation afro-Caribbeans); AC2 (2nd generation afro-Caribbeans); A1 (1st generation Asians); A2 (2nd generation Asians). Of the patients subject to the Act: • 16-29 year olds: UK 17%; A1 50%; A2 35.7%; AC1 48%; AC2 38.8%. • 30-44 year olds: UK 13.4%; A1 35.7%; AC1 60%. • 45 - pension age: UK 13.9%; A1 38.9%; AC1 57.1%. First admissions: • UK 9.5%; A1 21.7%; A2 25%; AC1 62.5%; AC2 27%. Re-admissions: • UK 16.8%; A1 51.3%; A2 40%; AC1 55.9%; AC2 44%. • 27% of UK psychotics compared to 36% of AC psychotics were detained. • 100% A, 48% of AC and 34% of UK psychotics under the age of 29 years were re-admitted. • Psychotic AC patients aged 30-44 were significantly more likely to be re-admitted than UK (65% compared to 26%). • Both A and AC in over 45 age group were significantly more likely to be re-admitted than UK.
Van Os, J., Fahy, T.A., Jones, P., Harvey, I., Sham, P., Lewis, S., Bebbington, P., Toone, B., Williams, M. & Murray, R. 1996	This study aimed to identify the underlying dimensions of psychopathology in 191 patients with functional psychosis of recent onset, and to examine their prognostic value.	• Lack of insight predicted more time in hospital and admission under a Section of the Act during the follow-up period. • The results show that psychopathological syndrome are considerably better predictors of illness course and treatment over the follow-up period than diagnostic categories.

(ii) What are the characteristics of patients detained under the MHA?

(a) Socio-demographic features

There are a number of studies, outlined in more detail below, which assess the likelihood of formal admission according to socio-demographic variables. Bebbington et al (1994) indicated that males are more likely to be sectioned than females. There is also good evidence that the proportion of admissions under the MHA fall with the age of the patient group studied (Patrick et al, 1989).

The most widely studied and important demographic variable in relation to the use of the MHA is ethnicity. The definition of ethnicity and individual ethnic groups is in itself a controversial area (Kwame, 1999). In this review we rely on the reporting of ethnicity in primary research papers, and use the groups as defined in the original reports. In general the pattern is remarkably consistent. Black individuals (defined variously as "Black - Caribbean", "Black - African", "Black – Other", and "Afro - Caribbean") are considerably more likely to be admitted formally than are whites. The limited research available (Thomas et al, 1993) suggests that Asian groups have intermediate rates of formal admissions and that they were not more likely to be detained than their white counterparts (Singh, 1998). The papers that describe this are shown in detail in table 2.1, but for simplicity table 2.2 summarises the main findings. This table shows that, on average, studies indicate that black individuals with psychiatric disorders are approximately twice as likely to be detained against their will than their white counterparts.

Table 2.2: Ratio of the proportions of formal admissions for black versus white patients

Paper	Ratio of proportion of formal admissions in black vs white patients
Bebbington	1.9
Davies	1.6
Johnson	1.2-1.5
Johnson	1.8-2.2
McKenzie	1.9
Patrick	2.0
Thomas	2.3-4.5
Singh	2.16

Few studies have assessed why this should be. There are a variety of potential reasons for the association. Patrick et al (1989) reported an interaction between ethnicity and age. In the younger groups, black patients were considerably more likely to be admitted than their white counterparts, but this relationship was reversed in older patients, with formal admission being more common for elderly white patients. Thus the association may result from confounding by age, if we assume that black people with psychotic illness are, on average, younger than white people with the same illnesses. Singh et al (1998) suggest that poor compliance with medication, greater denial of mental illness, greater delay in seeking help and a perception of psychiatric services as racist may well contribute to Black-Caribbeans resisting care when offered. However, their results still suggest that the stereotyping of this group as violent still probably influences the decision making process since perceived ethnicity was significantly associated with being young, diagnosed as psychotic and at risk of violence.

Bebbington et al's (1994) study suggested that most of the difference in the use of compulsion between ethnic groups was explicable in terms of the diagnosis of schizophrenia and presentations with challenging behaviour. Other such confounders are suggested by the study of Moodley and Thornicroft (1988), which indicated that black people were more likely to have been brought to hospital by the police, and a history of violence was more common in this group. In contrast, white patients were more likely to present with actual or threatened deliberate self-harm. Thomas et al (1993) suggested that some of the differences between black and white groups could be accounted for in terms of the prior contact these groups had with services. They demonstrated that black patients were less likely to have been in contact with services and suggested that this led to them to present at a later and more severe stage of their illness. In support of this, Singh et al (1998) suggested that since low numbers of black Caribbeans were admitted for non-psychotic illnesses their contact with mental health services was probably poor.

(b) Clinical features and diagnostic group

Not many studies have assessed the role of diagnostic group as a predictor of formal admission. Bebbington et al (1994) found that psychotic diagnoses were more common in those sectioned and affective disorders less common. Gilmore et al (1994) assessed diagnostic groups according to legal status in an elderly population, and found sectioned patients were more likely to have dementia than informal patients. Thus it appears likely that diagnoses that are associated with lack of insight, poor self care and threatened violence to others are more likely to lead to formal admission. This is borne out by

three other studies. As noted above, Singh et al (1998) found that compulsory detention was significantly associated with being diagnosed as psychotic, unemployed and being considered to be at risk of violence. In addition, Powell et al (1994) showed that a history of repeated violence in the context of mental illness is a risk factor for detention to psychiatric hospital, and Van Os et al (1996) showed that lack of insight into the nature of mental illness was associated with increased rates of formal admission.

(iii) What outcomes are associated with the use of the MHA?

The examination of outcomes of medical interventions is best addressed using randomised controlled trials. For ethical and political reasons this approach has not been used to assess the use of the MHA. With one exception, the reports described below are therefore mainly studies assessing the patients' views of their treatment under the MHA, rather than formal studies assessing clinical outcomes associated with the use of the Act. This means that any differences detected between patients detained under the MHA and informal patients could be due to confounding by diagnostic group and illness severity.

One study that actually addressed specific outcomes relating to use of the Act was Banerjee et al (1995). This study investigated the characteristics of the deaths of detained patients. Whilst there are many studies and reports on the deaths of mentally ill patients, particularly in relation to suicide, to our knowledge, this is the only report that specifically provides data on patients detained under the Act. The main cause of death in this study was 'probable suicide' which raised issues of staff training and clinical risk management policies.

One reason many clinicians may avoid using the MHA is the view that the future clinical relationship with the patient would be damaged. Certainly there is strong evidence that patients resent being sectioned at the time when it happens. Bindman and Reid (personal communication) describe in an (as yet) unpublished paper that patients perceived the experience of being sectioned as coercive, as indeed it is. The more intriguing result of this study was that many patients admitted informally also saw their admission as coercive – believing that were they to refuse treatment, they would have been admitted under the MHA.

Leavey et al (1997) assessed the satisfaction of patients and their relatives up to one year following admissions according to their legal status. The results of this study show that patients who were sectioned were less satisfied with all aspects of their care. This also applied to the families of such patients. The dissatisfaction was seen in a number of domains of care, including the information patients received regarding their treatment; their ratings of the "hotel" type facilities of their wards; the humane aspects of care; and the usefulness of any treatment they received.

A different picture is provided in another study that followed patients after admission. Johnson et al (personal communication) indicated that only a minority of white patients (10%) felt angry about their experience on follow-up, and only 25% felt that the section had been inappropriate. The pattern was

different for black patients with many more feeling angry they had been detained and 63% feeling the detention had been wrong. Rusius (1992) performed a similar study following up patients who had been detained against their will, and found that only 10% stated they were resentful having been admitted. However the pattern was different depending on the treatment received. Patients who had been treated against their will were much more likely to feel resentful, and this especially applied to patients given electro-convulsive therapy (ECT).

2.2.3 Future research into the MHA as a whole

Future research into the frequency with which the MHA is used will depend greatly on any changes made to the legislation. The use of routine data from the Department of Health and Home Office allows for broad trends to be described, as we showed in the first part of this report, but have two main limitations. Firstly, routine data do not give any information on the individual patients involved. It would be desirable to be able to use routine data to determine how frequently individuals had been sectioned, and to make links between the use of the MHA and the patients' individual characteristics (such as their age, gender, and diagnostic group). Secondly, there are no satisfactory denominator data.

The alternative approach is to identify well defined patient groups and to follow them over time as happened in the PRiSM studies (eg Davies et al, 1996; Johnson et al 1998). This approach is illuminating as it describes the experience of patients with psychosis in contact with services. However, psychosis is not the only psychiatric diagnosis leading to hospitalisation. It would be useful to have similar data on patients with alternative psychiatric diagnoses such as recurrent depressive disorders and personality disorders. Further studies might address the use of the MHA in other situations (for example patients presenting with self harm). Finally, much of the available data comes from Inner London. There is a paucity of data on the use of the Act in rural settings, and even in alternative urban centres.

With respect to the characteristics of patients detained under the MHA, the most obvious area to require further research is the finding that black people with psychiatric disorder are more likely to be sectioned than are white people. There exists a range of competing explanations for this finding. Firstly, as suggested above, it may be due to confounding by age, social deprivation, substance misuse or prevalence of certain diagnostic groups such as schizophrenia. If mentally ill black people are on average younger, are more likely to have schizophrenia and to come from deprived backgrounds, this might explain some of this excess use of the MHA. Certainly some studies cited here support this view.

Secondly, cultural factors in relation to patients from ethnic minorities may be important. Anecdotal accounts suggest there may be suspicion of psychiatric services among ethnic minorities, including patients, their families and the broader community. Such suspicion may lead to later presentations of mental illness, making emergency formal admissions more likely.

Thirdly, factors relating to the services themselves may be important. Different responses by professionals less likely to understand people from different cultural backgrounds lead to differential use of the MHA. Such factors are difficult to investigate using conventional observational research methods. In order to minimise respondent bias, future studies need to use objective and independent measures of risk management (Singh 1998). Furthermore, the over-simplification of data using polarised definitions of ethnicity and compulsory admission can be problematic and potentially inflammatory. Future research might concentrate on variables such as perceived ethnicity, perceived dangerousness, social support, severity of psychopathology, compliance and insight.

Regarding research into the outcomes associated with the use of the Act, it is perhaps unsurprising that some patient with mental illness of a severity requiring involuntary admission and treatment should remain resentful of psychiatric services. Patient satisfaction is not the only outcome which could have been addressed. Unfortunately, to answer questions related to the desirability and effectiveness of detention under MHA as a medical intervention requires randomised controlled trials. However such trials would be politically unattractive.

The non-randomised assessments of patient satisfaction reported above have compared patients according to whether they were admitted formally or informally. A more clinically relevant comparison, which has not to our knowledge been made, is that made between patients assessed for sectioning who are detained and those who are not detained. This comparison reflects the dilemma psychiatrists and social workers find themselves in when assessing acutely disturbed patients in community settings.

Part 2: Chapter 3 - Part II of the Mental Health Act (1983)

2.3.1 Introduction

This chapter assesses the use of Part II of the Mental Health Act (MHA) which allows a person to be compulsorily admitted or detained where this is necessary in the interests of his/her own health or safety and/or for the protection of other people. The sections comprising Part II are as follows:

Section of Part II	Powers provided under the Act
Section 2	Allows a person to be admitted to hospital for assessment for a maximum of 28 days
Section 3	Allows a person to be admitted/detained for treatment for between 6 months & 1 year
Section 4	Emergency admission for assessment only when Ss 2 or 3 cannot be used due to non-availability of a second opinion outside of the hospital
Section 5(2)	A doctor's holding power for informal patients
Section 5(4)	A nurse's holding power for informal patients for up to 6 hours or until a doctor becomes available (whichever is the earlier)

Where possible, the studies included in this chapter are discussed according to the specific section of the Act to which they relate. There were no studies relating specifically to Section 4. Studies relating to two or more sections of Part II are discussed separately. The chapter is centred around several main themes arising from the research into the different sections of Part II as follows:

1. Section 2: Factors governing the likelihood of appeal under Section 2.
2. Section 3: Patient discharge and extended leave.
3. Section 5(2): Appropriateness of application and implementation of Section 5(2).
4. Section 5(4): Factors affecting how and when Section 5(4) is applied.
5. Part II as a whole:
   (a) Trends in the implementation of Part II.
   (b) Characteristics of patients detained under Part II.
   (c) Outcomes associated with the use of Part II.
   (d) Interdisciplinary implementation of Part II.

2.3.2 Results

Of the 148 relevant articles identified, 46 papers are discussed in this chapter. These are summarised in tables 3.2 – 3.5. The majority of these reports are case-series and cross-sectional studies presenting data obtained from case-notes or reviews of section papers. The numbers of studies relating to each section of the Act are presented in table 3.1.

Table 3.1 – The literature available on each section of Part II

Section examined	Number of studies
Section 2	8
Section 3	3
Section 4	0
Section 5(2)	9
Section 5(4)	7
Two or more sections of Part II	19
Total Part II	**46**

(i) Part II: Section 2

The studies referring specifically to Section 2 are summarised in table 3.2. Eight papers were identified, but six of these were responses to a paper by Bradley et al (1995) and four of these contained no additional data. Thus, these four papers are not summarised in the table, although they are referred to in the discussion. Some additional studies relating to Section 2 in conjunction with other sections of Part II are presented in table 3.6.

Factors governing the likelihood of appeal under Section 2

Different rates of appeal by patients detained under Section 2 have been reported, including 9% (O'Dwyer and Neville, 1991), 13.7% (Naik and Klenka, 1995) and 27% (Bradley et al (1995). O'Dwyer and Neville (1991) found that of those who appealed, 83% were female (despite approximately even numbers of males and females being detained under this section) and 11.5% were of Asian origin. In the most prominent study published on Section 2, Bradley et al (1995), reported that the majority of appeals were to a Mental Health Review Tribunal, with 62.5% of all appeals reaching a hearing and 12.3% of these being discharged. However, these findings have been much disputed in the literature, involving criticisms to the study methodology (Langley, 1995) and questions as to the generalisability of the results (Naik and Klenka, 1995; O'Dwyer and Whitton, 1995).

Under the current appeals procedure, the patient is responsible for initiating the process in writing within 14 days. Such a system may discriminate against certain groups of patients. Bradley et al (1995) and O'Dwyer and Whitton (1995) have found the appeals procedure currently favours only well educated or previously admitted patients. Bradley et al (1995) also found that a diagnosis of depression or dementia or not receiving the information booklet significantly reduced the likelihood of appeal, with those who did not appeal scoring significantly lower on a test of knowledge. Such results have raised concerns about how satisfactory the methods are for informing patients of their rights when on a section. Bradley et al (1995) found 57% of patients detained under Section 2 were unaware of the appeals process, expressing concern that more patients would appeal if fully informed of their rights.

O’Dwyer and Whitton (1995) suggest a system by which all those detained under the Act are automatically reviewed by a local independent body with psychiatric input. Other suggestions for improvements to the appeals system include adopting the New Zealand method of having a judge available once a week to review all detentions as required (Turner, 1995), whilst the patients interviewed by Bradley et al (1995) suggested an automatic right of appeal. Bradley et al (1995) stress that an important distinction should be made between being mentally ill and too confused to make a decision to exercise one's rights. Langley (1995) and Burns and Raphael (1995) however, assert that the MHA contains extensive safeguards for patient civil liberties and before an increase in the rate of appeals is advocated, a greater understanding of the reasons for not appealing is required. Burns and Raphael (1995) refer to data from an audit showing that, despite the provision of advice and legal representation, the rate of appeal against detention under Section 2 is lower than reported by Bradley et al (1995).

Table 3.2 Part II: Section 2

Author and Year	Background	Main findings
Bradley, C.; Marshall, M. and Gath, D. 1995	This is a report of a case-note review and survey of patients admitted under S2 within the Oxford Regional Health Authority in 1993. The purpose of the research was to describe the characteristics of S2 patients (case-notes review, n=384) as well as establish their level of knowledge regarding their rights of appeal (interview, n=40). Raises issues about informing patients of their rights and generated a number of published responses in the literature **(see also Burns, T. and Raphael, F. 1995 (39), Langley, G. 1995 (37), O'Dwyer, J. and Whitton, I. 1995 (38); Turner, T. H. 1995 (40))**	• 50.6% of S2 patients and 42.5% of those interviewed were female. • Diagnoses: 39% schizophrenia; 13% personality disorder; 14% depression; 19% mania. • 57% unaware of the appeals process. • Not understanding/receiving information booklet significantly reduced likelihood of appeal. • Patients who did not appeal scored significantly lower on a test of knowledge. • Diagnosis of depression/dementia considerably reduced the likelihood of appeal. • Education to 'A' Level standard and having a previous admission almost doubled the likelihood of appeal. • 27% of all S2s and 30% of those interviewed had already lodged an appeal. • Following interview, 43% said they would now like to appeal.
Marshall, M.; Bradley, C. and Gath, D. 1995	A response to all letters criticising Bradley et al (1995) and providing additional information regarding appeals made.	• 104 patients appealed: 75 to MHRT; 15 to managers; 14 to both. • 65 reached a hearing: 6/47 to tribunal, 2/8 to managers and 0/10 to both were discharged.
Naik, P. C. and Klenka, L. 1995	This was a letter containing data from a case-note audit of 255 patients detained under S2 of the MHA in an unspecified hospital. Published in response to Bradley et al (1995).	• 35/255 (13.7%) appealed against S2. • Data very different from Bradley et al's (1995); this may be due to the diagnostic groups in the two studies differing.
O'Dwyer, J. and Neville, P. 1991	This was a letter containing details of 400 patients who appealed against S2 in a district health authority. Little information due to letter format.	• 36/400 (9%) appealed. • 53% of the total sample and 83% of those who appealed were female. • 1.5% of those originally admitted (33% of total who appealed) were released. • 15.5% of total and 11.1% of those who appealed were Asian - none were released.

(ii) Part II: Section 3

Only three papers were found to address the use of Section 3 specifically. One paper reports on details of the outcome of patients discharged from Section 3. The other two are related papers that investigate the use of 'extended leave' under Section 3. These studies are summarised in table 3.3.

Patient discharge and extended leave

Since 1988, Section 3 orders have risen and more patients have been detained for longer than 33 weeks. This increase in use of Section 3 suggests it might be being used in preference to Section 2. Sackett (1996) found that over time there was a significant reduction in the numbers detained for over 13 weeks and a trend towards earlier discharge, perhaps suggesting less ill people were being sectioned and reflecting pressure on beds. The same study also reported a decrease in expired Section 3 orders and that the proportion discharged by RMO significantly increased over time. Sackett suggested that detentions of less than 28 days should not be of concern because the Code of Practice states that the RMO should rescind the section at the earliest opportunity.

Sensky et al (1991a and 1991b) found factors associated with extended leave patients to be a history of persistently poor compliance with treatment including outpatient attendance, a more frequent history of serious dangerousness, and numerous admissions. However, there seems to be a group of psychiatric patients who benefit from extended leave, resulting in shorter admissions, a marked improvement in compliance, and for half, improved in ratings of dangerousness to others (Sensky et al 1991a). Without the possibility of compulsory outpatient treatment, the outcome for this group of patients may be poor, particularly in terms of remaining in the community (Sensky et al 1991a and 1991b).

Table 3.3 Part II: Section 3

Author and Year	Background	Main findings
Sackett, K. 1996	This study examined factors associated with discharges from S3 on a total of 350 patients in an unspecified setting over a 10 year period.	Over the study period 1985 to 1994: • The number of appeals to MHRTs and managers rose from 15 to 48. • Discharges rose from 2 to 4 over the same period. • S3 renewals declined from 10% to 5%. • The proportion of S3s allowed to lapse decreased from 30% to 18%. • Discharges from S3 to informal status increased from 25% to 36%. • Patients remaining in hospital for between 0 and 13 weeks rose from 36% to 60%.
Sensky, T.; Hughes, T. and Hirsch, S. 1991a	This study was a case-note review of 35 patients subject to extended leave on a S3 in an unspecified setting. Study compared those subject to extended leave with those who were not.	• 57% of total sample was male. • 88% had had previous MHA admissions. • 53% of control compared to 19% of subject group had no previous MHA admissions. • Subjects spent longer in hospital than controls before their extended leave. • 56% of subjects had a reduced number of admissions while on extended leave. • 67% spent less time as inpatients during extended leave than before. • 48% unemployed for more than 3 years. • Subjects were less likely to comply with outpatient attendance • 44% of subjects compared to 2% control were lost to follow up in less than 12 months. • Compliance with outpatient attendance improved in 43% of cases during extended leave. • Previous drug overdoses were recorded in 29% of extended leave episodes and 33% of control. • Case notes were not of a consistently adequate standard to reliably record a clinical profile.
Sensky, T.; Hughes, T. and Hirsch, S. 1991b	Provides additional information to Sensky et al (1991a). This was a survey asking psychiatrists to identify the patients in a psychiatric hospital they would select for Community Treatment Orders if they existed.	• A total of 78 patient profiles were studied, 29 subjects and 49 control. • 45% male and 55% female. • Subject group spent more time as a compulsory admission and had more MHA admissions than control. • 72% of subjects compared to 63% of control were unemployed for more than 3 years. • 62% of subjects lived alone compared to 43% of control. • Subjects were less compliant with outpatient attendance than control.

(iii) Part II: Section 5(2)

Nine studies were found to report on the use of Section 5(2) specifically. These are summarised in table 3.4. The majority of these studies are letters detailing the results of audits. One study was a survey of hospitals investigating who the 'nominated deputy' was in applying this section.

Appropriateness of application and implementation of Section 5(2)

The studies reporting findings on when Section 5(2) was implemented produced conflicting findings. The majority of sections were found to be implemented outside office hours (Buller et al 1996; Hall et al 1995; Joyce et al 1991; Mason & Turner 1994; Pourgourides et al 1992; Salib and Iparragirre 1998) and more than 24 hours after admission (Hall et al 1995; Salib & Iparragirre 1998). However, two studies found the reverse, with the majority of sections being implemented within 12 or 24 hours of admission (Mason & Turner 1994 and Brown 1991 respectively). In line with these findings, Brown (1991) and Joyce et al (1991) suggested that better preparation or assessment at home might prevent patients being detained within 24 hours of admission.

Brown (1991) reported finding no evidence that Section 5(2) was being abused as an expedient measure to detain patients. Many authors felt that the use of Section 5(2) as a means of short detention was not only acceptable, but indicative of the need for a short period of detention in times of crisis (Hall et al 1995; Mason & Turner 1994; Salib and Iparragirre 1998). Inappropriate use of Section 5(2) was, however, suggested by a number of authors, particularly in relation to the high numbers not converted to either Sections 2 or 3 (Li 1993; Mason & Turner 1994; Pourgourides et al 1992; Buller et al 1996). Salib & Iparragirre (1998) found that there was no significant change in the rate of conversions over the past ten years and note that the high rate of non-conversion could highlight the difficulty in obtaining second opinions from doctors or ASWs.

Patients were more likely to be converted to either Section 2 or 3 if there was evidence of mental illness or suicidal ideation, if the section had been preceded by a Section 5(4), or if the section was invoked by a senior psychiatrist (Buller et al 1996; Salib & Iparragirre 1998). The reasons for conversion or non-conversion of a section were often poorly documented (Mason & Turner 1994; Salib and Iparragirre 1998). Better documentation procedures and improved training of doctors in relation to the assessment and conversion of Section 5(2) was recommended (Pourgourides et al, 1992; Brown 1991; Cooper & Harper 1992; Li 1993; Salib and Iparragirre 1998).

Due to differences in the organisation of services throughout the country there is variation in who is available and qualified to be the nominated deputy. Most sections are being applied by junior doctors, most of whom are not in contact with consultants (Cooper & Harper 1992; Hall et al 1995; Joyce et al 1991). However, some have suggested that in many cases, Section 5(2) is being implemented or signed by the consultant raising queries as to why Sections 2 or 3 were not implemented in the first place (Pourgourides et al 1992; Salib and Iparragirre 1998).

Table 3.4 Part II: Section 5(2)

Author and Year	Background	Main findings
Brown, N. S. 1991	This report was a letter detailing the results of an audit of 33 patients detained in an unspecified hospital under S5(2). It is difficult to ascertain whether the audit cycle was complete from this report. Improvements were suggested and with recommended follow-up in future audits.	• 48.5% male and 51.5% female. • 20 were admitted by either the consultant or a junior doctor from the home team. • 32 were assessed by medical staff. • 11 were detained within 24 hours of admission. • 14 were detained during office hours. • 21 were converted to S2 or S3. • 25 had one or more previous admissions.
Buller, C.; Storer, D., and Bennett, R. 1996	This report contained data from an incomplete audit cycle. The case-notes of 26 patients in a general hospital subject to S5(2) were used. Recommendations were made but no data is available to demonstrate whether such recommendations resulted in improved practice.	• 57.6% male and 42.4% female. • 36% of S5(2)s were implemented by non-psychiatrists; 78% of these sought a psychiatric opinion. • 63% were detained outside office hours. • The reason stated for detaining 77% of patients was the risk of absconding. • 31% converted to S2; 23% converted to S3; 27% rescinded; 19% allowed to lapse. • Of those left on a general ward, 24% were not reviewed by psychiatrist within 24 hours. • 88.4% were given a psychiatric diagnosis on first contact.
Cooper, S. A. and Harper, R. 1992	Audit of 152 hospitals in England and Wales covering 6955 S5(2) detentions. Postal questionnaire used to ascertain who acts as the nominated deputy on behalf of the RMO for the implementation of S5(2). No data on the S5(2) patients, therefore difficult to establish whether the difference in nominated deputies has an effect. Recommendations made but no data from follow-up audits available.	• Outside normal working hours 79% of nominated deputies were the on-call registrars. • During normal working hours this became more divided between the on-call SHO/registrar and a specified SHO/registrar. • There was much variation between and within health districts.
Hall, A. D.; Puri, B. K.; Stewart, T., and Grahame, P. S. 1995	To determine differences in practice, this report presents case-notes of 61 patients subject to S5(2) in an unspecified hospital.	• 68% of sections were implemented by registrars or SHOs. • 35% took place within office hours. • 33% took place within 24 hours of admission; 42% after 72 hours of admission. • 96% of patients detained within 24 hours were psychotic. • 26% converted to S2, 16% converted to S3; 7% to informal; 51% allowed to lapse. • Conversions to S2 and S3 significantly more likely during the week than at the weekend. • Grade of doctor initiating S5(2) made no difference to outcome. • 54% of psychotics re-graded to S2 or S3; significantly higher than non-psychotics.

		• 3 patients were probably illegally detained.
Joyce, J.; Morris, M., and Palia, S. S. 1991	This was a letter reporting the results of a small and incomplete audit of 42 patients in psychiatric hospital subject to S5(2). The demographic characteristics of the patients are not reported. Recommendations were made but no follow-up audit is available.	• 86% of sections were implemented by a junior doctor. • 38% were detained within 24 hours of admission. • 93% of cases were assessed by RMO within 24 hours but 3 cases not assessed at all. • Friday was the most common day for the implementation of S5(2). • 48% converted to either S2 or 3; 21% rescinded; 31% allowed to lapse.

Table 3.4 (continued) Part II: Section 5(2)

Author and Year	Background	Main findings
Li, D. 1993	This report is a letter outlining the results of an audit on an unspecified number of patients detained under S5(2) in an unspecified setting. The demographic characteristics of patients are not reported.	• 73% of detentions made by SHOs. • 41% made by those in their first psychiatric post; only 18% sought advice. • 41% of section applications made within 12 hours of the patient being admitted. • The majority of SHOs denied having received any kind of training in the use of S5(2).
Mason, P. and Turner, R. 1994	This is a report of a large scale audit in Lincoln and Nottingham over one year. Used 146 case-notes and section papers of patients detained under S5(2). Although audit cycle is almost complete with policy changes having been implemented, there is no follow-up data to suggest whether such policy changes have improved practice.	• 55.5% S5(2) patients were male. • 69% were sectioned out of working hours. • 63% were sectioned at least 12 hours after admission. • 47.9% were converted to S2 or 3; 1.4% rescinded; remainder allowed to run the course. • Significantly fewer conversions occurred at the weekend. • Patients significantly more likely to be converted to S2 or 3 if suffering from psychoses, affective disorders and organic disorders than personality disorder, stress reaction and substance abuse. • Less likely to be converted if detained within 12 hours of admission. • Junior doctors who sought advice had a higher conversion rate.
Pourgourides, C.; Prasher, V. P., and Oyebode, F. 1992	An incomplete audit of 189 patients who were subject to S5(2) in a psychiatric hospital. The patients were identified using MHA forms so it was not possible to establish whether the correct form was used. It was also assumed that a signature by a junior doctor indicated a nominated deputy, but there was no evidence to support this.	• 58.2% S5(2) patients were female. • 79% sectioned by junior doctors; 21% by the RMO. • 45.8% of sections implemented during working hours. • 36% converted to S2; 14.8% to S3; 47.6% rescinded; 0.03% allowed to lapse. • 6 detentions were allowed to lapse before a S2 or 3 was subsequently applied.
Salib, E. and Iparragirre, B. 1998	The case-notes and section papers of 877 patients detained on a S5(2) in a regional area were examined to record demographic details and trends in the use of the section.	• 53% S5(2) patients were female. • 41% detained by consultants; 59% by nominated deputies. • 27% were implemented during office hours. • 65% of sections were implemented at least one week after admission. • 44% were detained for reasons of acute psychosis. • 45% converted to S2; 12% to S3; 43% rescinded; 16% allowed to lapse. • 16% of detentions had been preceded by S5(4). • 84% were assessed within 48 hours. • 90% of patients with psychosis, 60% with hypomania, 51% with depression, 45% of organic and 40% of behavioural conditions were converted. • Authors comment that there is no evidence to suggest inappropriate use, despite the 43% unconverted and 16% lapsed sections.

(iv) Part II: Section 5(4)

Seven studies specifically addressed Section 5(4). These are presented in Table 3.5. One of the seven, Ashmore (1991), reported preliminary findings that are incorporated in a later publication (Ashmore, 1992a). Consequently it is summarised as part of the latter report. Half the papers related to trends in use and demographic details of patients subject to Section 5(4). The remainder focused on nurses' knowledge and opinion regarding this particular Section of the Act.

Factors affecting how and when Section 5(4) is applied

The commonly held belief that Section 5(4) is used most at weekends was not empirically supported (Ashmore, 1992a), with a large amount of sections being applied during office hours (Dimond, 1989; Bowler & Cooper, 1993). It was noted that many doctors were absent from the wards for half a day at a time and that many Sections 5(4) were implemented when an RMO might have been available (Ashmore, 1992a). There was a high number of Sections 5(4) implemented on the day of admission (Bowler and Cooper, 1993; Dimond, 1989). Contributing factors in the implementation of this section include high patient-staff ratio, increase in patient-patient interaction, no RMO and visiting periods (Ashmore, 1992a).

Reasons for not finding the power useful included 'too much responsibility for a RMN' and 'too much trouble for 6 hours' (Ward 1991). Ward (1991) suggested a nurse must be able to justify why s/he did not use the power if an incident occurs when an informal patient leaves the ward. Most nurses were glad they had the power as it ensured their legal protection and any uncertainties were removed (Dimond, 1989). They were more reluctant to use their powers than likely to abuse them, often preferring to persuade the patient to stay on an informal basis (Dimond, 1989; Harrison, 1997; Ward, 1991). A lack of knowledge surrounding the correct application of the Act was identified (Ashmore, 1992b; Ward, 1991) leading to an appeal for increased training in risk assessment skills and increased communication between agencies with the multi-disciplinary team in terms of patients' previous histories (Bowler and Cooper, 1993; Harrison, 1997). Ward (1991) suggested that low usage of Section 5(4) was not only due to a lack of confidence in applying the section, but also that nominated medical deputies were often available to apply Section 5(2) when emergencies arose. When patients were interviewed, many were disbelieving that nurses had this power (Dimond, 1989). Social Workers were the most disquieted about the use of this section, whereas doctors were inclined to support its use by nurses (Dimond, 1989). It was noted that in emergency situations nurses should apply 5(4) rather than common law, but that the patient detained under 5(4) has no legal right to appeal against it (Bowler and Cooper 1993).

The most common outcome of the use of Section 5(4) was for a Section 5(2) to be implemented (Ashmore, 1992a; Bowler and Cooper, 1993; Dimond, 1989). It was claimed that the reason most Sections 5(4) were converted to a further section was due to the strong influence of the 'medical model'. Doctors were thought to be more likely to agree with nurses because the patient has already been labelled as dangerous using a medical model. This would have serious implications for the psychiatric interview and any subsequent decision to extend the section (Ashmore, 1992a). Ashmore (1992a) also highlighted the potential problems associated with spending longer than necessary on a section, such as greater likelihood of increased anxiety for staff and patients, with the possibility of aggression, need for medication, and further damage to the therapeutic relationship. In addition, Dimond (1989) suggests a failure to link seclusion policies with the power, as well as uncertainty over the manner of carrying out the detention leading to further unnecessary distress and uncertainty.

An awareness of the factors which may influence a nurses decision to implement Section 5(4) could reduce the need to use this emergency nursing intervention (Ashmore, 1992a; Bowler and Cooper, 1993; Ward, 1991). Ashmore (1992a) attempted to explain some of the findings in relation to seasonal variations, but provided little evidence in support of this, particularly since the study period was only one year.

Overall, it would appear that Section 5(4) maybe under-used. The very low rates of use of Section 5(4) and the fact that the majority of these sections are converted indicates that nurses' powers are unlikely to be abused. Furthermore, there is little evidence to suggest any changes in the numbers of patients who abscond under this section.

Table 3.5 Part II: Section 5(4)

Author and Year	Background	Main Findings
Ashmore, R. 1992a	This study collected data on the use of S5(4) over a one year period. 75 patients' section papers from 6 wards in a psychiatric hospital were used. **(See Ashmore, 1991, for preliminary data)**	• 45.3% male and 54.7% female. • 3.8% of total were detained under S5(4). • The majority of sections occurred between 4pm and midnight, with fewer detentions before and after the weekend. • 72 out of 75 patients were transferred to either Section 5.2 or S2, one patient to informal, 1 lapsed and 1 absconded. • The average length of detention was 2 hrs with 8 patients spending 5-6 hrs under section.
Ashmore, R. 1992b	This was a survey of 42 psychiatric nursing trainee finalists investigating their knowledge of the correct use of S5(4). Setting and demographics of sample unknown. Small study highlighting nurses' knowledge of their own sectioning powers prior to graduating. Raises important issues surrounding nurse training.	• Given a maximum score of 17, scores ranged from 6-15 with a mean of 9.62. • The majority knew that the patient must present a danger to themselves or others in order to be detained. • Only 35 were correct in stating that the section could be applied to an inpatient suffering mental disorder. • 34 knew it lapsed after 6 hours. • 30 knew that the patient could not be treated against their will. • 41 knew that the implementation of the Section was a nursing decision only and could not be influenced by a doctor. • 10 thought the patient could be detained again under S5(4) if it lapsed; 11 would consider holding them under common law; 8 did not know and only 3 would allow the patient to leave.
Bowler, C. and Cooper, S. A. 1993	This report presents data from an incomplete audit cycle of 99 sets of case notes of patients subject to S5(4) in a general hospital. Conversion rates and demographic details are examined. No information on any follow-up audits although recommendations are made.	• 42% male and 58% female. • 37.4% of Sections were implemented during working hours and 50.5% implemented more than 3 days after admission. • Of reasons for sectioning, 50.5% were for suicide risk and 36.4% because of refusal to stay informally and psychosis. • 85% were converted: 6% to S2, 1 to S3, 78.7% to S5(2), 14% rescinded and none were allowed to lapse. • 94.9% were originally admitted informally, 4% on a S2 and 1 on a S4. • 28.3% of Sections were applied on the day of admission.
Dimond, B. 1989	This was a survey of nurses and other professionals (although demographic details of sample unknown) in a particular region. The primary aim was to report the opinions of professionals on the use of S5(4), although data was presented on the actual use of S5(4). However, no information was provided as to the source of the data and it	• 32 patients were subject to S5(4). • 30 were sectioned within 6 hours of admission. • 15 detained during office hours and 4 at the weekend. • 1 was converted to S2, 3 to S3, 16 to S5(2) and 3 to informal.

	is not clear how some of the figures add up. The opinions of professionals are not presented in full.	

Table 3.5 (continued) Part II: Section 5(4)

Author and Year	Background	Main Findings
Harrison, S. 1997	A dissertation summarising five papers on the reasons for low use of S5(4).	• In one 30 bedded unit, S5(4) was only used twice over two years; S5(2) was used 34 times in that period. • Nurses appear to prefer to use common law and persuasion rather than legal detention and to allow a doctor to make the decision for them. • Risk assessment is considered a difficult area with consideration of legal implications if the wrong decision is made. • Lack of knowledge of the Act is a likely contributor to its low use. • S5(4) and risk assessment are still not covered thoroughly enough during nurse training. • Not enough nurses use the power to be able to compare experiences. • When the section is applied it appears to be done so correctly with a high conversion rate.
Ward, J. 1991	A survey of 33 nurses in an unspecified setting to establish their knowledge on S5(4). This was to be compared with the incidence of sectioning but could not be achieved owing to the fact that only two of the respondents had ever used the power. Little information available as to the methodological quality of this study.	• 45.5% nurses did not know that patients must be being treated for a mental disorder at the time of detention. • 48.5% thought that patients could appeal against their section. • 84.8% knew that patients can refuse medication and have the same rights as an informal patient. • 18% thought they had to be instructed by a doctor to use the power. • Half did not know that 1st level psychiatric and mental handicap nurses can also use the power.

(v) All of Part II

Nineteen studies include information on two or more sections of Part II. These papers addressed a range of topics including demographic, ethnic and diagnostic details of patients referred for assessment/detained under Part II, general trends in the use of various sections, and professional issues associated with this part of the Act. Table 3.6 provides details of papers that refer to the use of two or more sections under Part II of the Act. Several main themes could be identified in these studies. These generally mirrored topics discussed in other chapters of this report. The themes discussed here are as follows:

(a) Trends in the implementation of Part II.
(b) Characteristics of patients detained under Part II.
(c) Outcomes associated with the use of Part II.
(d) Interdisciplinary implementation of Part II.

(a) Trends in the implementation of Part II

This topic is discussed in relation to the data presented in Part 1 of this report. Many of the studies related to Part II highlight the limitations of DH data in estimating the extent and frequency with which the Act is used. This could partially explain the discrepancies between many of the reported findings. DH figures provide data on admissions but do not give any indication of the number of those considered for detention which actually end up in hospital (Barnes, 1990). Some studies report that Section 2 requests have remained stable, Section 3 requests have risen, and Section 4 requests have decreased (Bowl et al, 1987; Huxley and Kerfoot, 1993, Hatfield & Robinshaw, 1994). There was some disagreement about the use of Section 2, with one study reporting a small increase and the other a small decline. Between 1990-91 there was a marked rise in the number of Approved Social Workers (ASW) being requested to assess an increasing number of people subject to Section 5 of the Act, accompanied by a decrease in the number of informal patients assessed (Hatfield and Robinshaw 1994). Overall, as noted in Part 1 of this report, the use of Section 3 is reported to have increased and Section 4 decreased (Durani and Ford, 1989; Hatfield and Mohamad, 1994; Mortimer 1990; Webster et al 1987); although an early study by Winterson and Barraclough (1984) showed an initial decline in the use of Section 3. Webster et al (1987) suggested the increase in Section 3 use could be partly explained by the need to renew the detention of some patients after 6 months rather than just one year. These authors also reported that the number of compulsory admissions to large psychiatric hospitals declined significantly over their study period immediately following the introduction of the MHA. Whilst it is possible that such a decline was observed in this study during this period, the DH figures presented in

Part 1 of this report highlight a rapidly changing picture over the 12 year period since then, in which the overall number of formal admissions has increased dramatically.

Puri & Bermingham (1990) suggest an increase in Section 4 admissions is balanced out by the low use of Section 136 in low density urban populations and areas with low proportions of ethnic minorities as well as good Social Worker support. However, it is unlikely that any service could eliminate the use of emergency sections and there must be some occasions where they are appropriate when a delay would be undesirable (Huxley and Kerfoot 1993).

(b) Characteristics of patients detained under Part II

Barnes (1990) reported a range of factors affecting the use of Part II and the outcomes associated with it, including characteristics of patients, attitudes of professionals, as well as the absence of a clear definition of mental illness. In line with the observations made in Chapter 2 of this report, age and gender have been identified as key variables in the identification of mental illness with younger men and older women characterising the population (Barnes, 1990; Hatfield & Mohamad, 1994; Hatfield et al, 1992; Hatfield & Robinshaw, 1994; Mortimer, 1990; Sheppard, 1991). Barnes (1990) reported that patients over 65 years made up one fifth of referrals, but were less likely to be detained. However, Puri et al (1992) found no significant differences in terms of gender. There was a close relationship between Section 4 and an index of social deprivation, but only in London authorities (Huxley and Kerfoot, 1993). Those in unpaid employment were reported to constitute nearly three quarters of all those referred (Hatfield et al, 1992). Bowl et al (1987) suggested that a number of Section 4 referrals were not in fact mentally ill. Such findings contrast with those of Hatfield et al (1992) who reported that 90% of Section 4 requests led to compulsory detention. Hatfield and Mohamad (1994) also reported an increasing number of assessments involving younger men with schizophrenia, commonly the same men repeatedly, suggesting this largely accounts for overall increases in the use of the Act. Early indications of Hatfield & Robinshaw's (1994) monitoring exercise showed that increases in compulsory detentions, for people aged over 75 years were not largely accounted for by people with a primary diagnosis of dementia. Affective psychosis and depression were more common in these cases. They also found that although the number of detentions increased over time but involved fewer people, suggesting a pattern of repeated short term detentions of chronically vulnerable individuals. Other figures indicate a greater likelihood of detention following assessment for patients already in hospital than for the group as a whole (Hatfield et al, 1992). Voluntary services and other non-specified help was used to prevent hospital admission more in black than white patients (Barnes 1990). Barnes (1990) reported that Asians referrals were more likely to come from GPs or psychiatrists but referrals of black people more likely

to come from the courts or the police. These findings echo the observations made in Chapter 2 of this report which suggested that differences in diagnoses and presentation might partially explain some of the reported difference between ethnic groups.

(c) Outcomes

In terms of outcome, Puri & Bermingham (1990) and Puri et al (1992) reported that over half of Section 4 patients were converted to informal status. However, patients regraded from Section 4 had a significantly longer stay in hospital than informal patients (Puri et al, 1992). Webster et al (1987) reported that Sections 5(4) were often either converted to Sections 5(2) or to informal status. Section 2 was often left to expire (Mortimer, 1990). The number of MHRT hearings rose dramatically following the introduction of the MHA (1983), although they resulted in few discharges before and after the Act (Webster et al, 1987). A number of authors have suggested that increased resources and specialist units would improve outcomes for detained patients (Bowl et al, 1987; Hatfield et al, 1992; Nasser et al, 1993; O'Dwyer & Mann, 1989).

There are questions over the need for such a high number of requests out of hours and Bowl et al (1987) suggested that resources could be better accessed during working hours thereby helping to reduce admissions. As noted earlier in this chapter, this is in marked contrast to criticisms in other studies that suggest 'out of hours' services would be more beneficial. Mortimer (1990) recommends that sections are ended as soon as it is prudent to do so in order to reduce the amount of stress caused to patients and families.

(d) Interdisciplinary implementation of Part II

Sections 2 and 3, the most commonly used sections of the MHA, require the agreement of social workers and two doctors – one of whom is usually the patient's GP. Ways in which the Act is applied by different professional groups has therefore received some attention. The availability of information on different groups of patients at the referral stage differed between professional groups, with ASWs showing great flexibility in their responses (Sheppard, 1991). Several authors expressed concern that Social Workers were borrowing and adapting practices too much in terms of a medical approach and that their skills were merely being used to overcome patients' fears of entering hospital (Barnes 1990; Bowl et al 1987; Sheppard 1991). Barnes (1990) and Hatfield et al (1992) have suggested that if Social Workers are to retain more than a procedural role in the MHA, they must play a part in developing practices which could provide alternatives to medical treatment, although it is not clear what these might be.

There was considerable variation between authorities in terms of making applications under the Act. Specific requests for detention more often resulted in detention than did general requests for assessment (Hatfield et al 1992), but individual policies and practices of agencies were reported to affect the number of requests for detention (Barnes, 1990). Clearer policies and increased accessibility to community based psychiatric services were recommended as an improvement to current referral systems (Barnes, 1990; Bowl et al, 1987). Emergency residential accommodation was seen as a way of preventing 40% of admissions, yet was only available in 2 of the 42 authorities. Dutta & Fleet (1991) reported on a new crisis intervention centre which was to be evaluated in future audits. Shortfalls also occurred in family support, social work resources and GP services (Bowl et al, 1987). Despite the detailed studies provided by local authorities, the differences between them made it difficult to draw any conclusions about the whole population and several authors called for a standardisation of data collection (Barnes, 1990; Huxley and Kerfoot, 1993).

Section 3 patients were found to be most likely to be detained by agreement of ASW and these referrals were often well known to services (Bowl et al, 1987; Hatfield et al, 1992). Bowl et al (1987) reported that social workers were less likely to agree to admission in response to requests for Section 4 with a high rate of Section 2 and Section 4 referrals being persuaded to enter hospital informally (Bowl et al, 1987; Hatfield et al, 1992). Webster et al (1987) suggested that the move away from compulsory admissions towards voluntary admissions was a positive contribution by Social Workers. Hatfield et al (1992) reported that one third of Section 4 requests were detained under Sections 2 or 3. Further discussion of this issue can be found in Chapter 6 of this report.

Table 3.6 All of Part II

Author and Year	Background	Main findings
Barnes, M. 1990	Summary of results from the SSRG study (Barnes and Prior, 1984). This was a large cross-sectional study of 9405 MHA assessments from 42 local authorities referred to social services. It provides information on outcome for patients referred for compulsory detention under Sections 2, 3, 4 and 136 of the Act.	• 68.4 per 100 000 males were referred, 50% detained. • 82.5 per 100 000 females were referred, 52% detained. • Between 47% - 65% of social services clients experience some mental health proble • Spending on mental health services within social services is less than 2%. • Where hospital admission was prevented, family support was used for 47% of women and 39% of men. • 44% of the over 65s were compulsorily detained. • Domicillary services used more often (25%) in elderly cases than others (12% overall). • 80% of afro-Caribbeans were detained compulsorily compared to 59% of white and Asian groups. • A higher proportion of afro-Caribbeans were referred by the police or courts.
Bowl, R.; Barnes, M., and Fisher, M. 1987	An earlier summary of the SSRG project data providing additional information. A large part of this study argues the case for social services input based on data that is not provided. Although the SSRG project data was used, it was not referenced.	• 85% of S3 requests were detained with 2.5% admitted informally. • 71.6% of S2 requests detained, with 10% admitted informally. • 60.6% of S4 requests were detained with 17.2% admitted informally. • Between 1984 and 1985/6 the number of S3 admissions rose from 14% to 26%; S4 admissions declined from 29.4% to 15.1%; S2 admissions rose from 55.9% to 58.4%. • ASWs felt that 25% of compulsory admissions and 29% of all admissions could have been diverted into alternative care if resources had been available.
Cope, R. 1989	Paper provides a summary of findings in four studies. Four-year detention rates per 100 000 population were examined in relation to first admissions and compulsory detentions in white and Afro-Caribbean patients in Birmingham. The majority of findings relate to Part III of the Act but those relating to Part II are reported here. The 1959 Act was in operation for the whole of the research period (1975-1983). The authors however used corresponding sections of the 1983 Act for clarity and thus this study is included here.	Compulsory detention rate per 100,000: • Male: White 59, Black 408; Female: White 83, Black 179. • Migrant Afro-Caribbeans males' and British born Afro-Caribbeans males' admission rates were 17 and 9 times respectively that of white males. When the high rate of psychotic diagnosis in the Afro-Caribbeans group is taken into account this difference almost disappears. • The high rate could be partially explained by excess of admissions with schizophrenia. • The second generation had the highest compulsory admission rates which could be accounted for by differences in the total number of admissions and diagnosis.
Durani, S. K. and Ford, R. 1989	A six year study of changes in admissions to one unspecified hospital 3 years before and after the introduction of the MHA (1983) (n = 7072). The authors indicated that there was a real association between the MHA (1983) and an increased rate of formal admissions,	• There were no consistent change of use in the over 65 age group. • S2 decreased from 54% to 40% prior to the Act and then increased to 74% in 1983/4 decreasing to 67% in 1985/6. • S3 increased gradually from 4% in 1980/1 to 18% in 1985/6. • S4 was used frequently before the Act; between 37% and 44% pre 1983, not

	although they do not provide adequate data to substantiate this claim.	rising above 10% in use post-1983.

Table 3.6 (continued) All of Part II

Author and Year	Background	Main findings
Dutta, A. and Fleet, T. W. 1991	A case note audit of 140 patients discharged over one month from a psychiatric hospital and the psychiatric ward of a general hospital. No breakdown of sections of the Act; data refers to Part II only and includes S2, 3 and 4. Focus was on reporting audit work; reference to the Act coincidental.	• 47.1% male; 52.9% female. • Mean length of stay was 27.5 days in the psychiatric hospital and 37.8 days on the psychiatric ward of the general hospital. • Diagnoses: 45 diagnosed as schizophrenic; 25 as having a psychotic condition; 24 with alcohol/drug dependency; 10 with depression.
Hatfield, B. and Mohamad, H. 1994	A cross-sectional study of the differences between men and women in the application of the Act (n = 4401). 5 local authorities were studied. Many of the findings presented are not of any statistical significance. Nevertheless, this is a large and detailed study revealing differences between men and women in the application of the Act.	• 55% male; 45% female. • 64% of the under 20 age group were male. • 71% of the over 65 age group were female. • 66% of men were single compared to 30% of women though for both men and women being single was the most common marital status. • Majority of women lived with a partner &/or their children; majority of men lived alone. • 55% of those detained under S2, 3 or 4 of the Act were women. • Male admissions under S2 rose between 1990 & 1993 whilst female admission declined. • Male admissions under S3 rose gradually over time. • Female admissions also increased although there was a slight decline in 1993.
Hatfield, B.; Mohamad, H., and Huxley, P. 1992	915 subjects, 1262 incidents. A preliminary release of figures from one years investigation of referrals for assessment to social workers. 5 local authorities in one area. Repeatedly addresses the point that ASWs provide alternative outcomes to patients referred to them for assessment. It does not address criticisms in other studies that ASWs are often not available or unwilling to take part in the assessment of patients referred for detention under the Act.	• Males: Considered under the Act 40.8%; Detained 42.9%. • Females: Considered under the Act 59.2%; Detained 57.1%. • 21-30 age group were most considered for action under the Act. • Of those referred: 63.1% were already known to social services; 51% were unemployed; 30% were living alone. • Those admitted compulsorily: S2 67.8%; S3 84.8%; S4, 90%. • Diagnoses: 30% schizophrenia; 33.1% affective psychosis. • Request for assessment: 63% for S2, 30% for S3 and 7% for S4. • Gender: 51.5% of schizophrenics were men; 69.9% of depressives were women. • 28.4% of detentions had hospital SWs as applicants. • 80.5% of requests culminated in application for detention. • 73.9% of all requests for assessment culminated in detention. • 72.6% of incidents came from people known to social services.

Table 3.6 (continued) All of Part II

Author and Year	Background	Main findings
Hatfield, B & Robinshaw, P. 1994	A second preliminary report on monitoring the workings of 5 local authorities (See Hatfield et al 1992 and 1997). The two main aims of this paper are to 1) provide an examination of trends in assessments for compulsory detentions within the three principal sections of the Act and, 2) to explore the rate at which the over 75'' are assessed under the Act.	• From 1990-91 there was a 13.4% increase in the number of requests for assessment • Requests for assessment for S3 increased y 16.3%; S2 by 7.6%; S4 by 5.8%; and general assessments by 25.9% • There was an 8% increase in S2 detentions; 20.3% in S3; and S4 detentions decreased by 31.6% **1990** • Of all sections used; s2 58%; s3 34%; s4 8% • Rate of compulsory admissions was 22 per 100 000 • Rate of requests to assess was 73.2 per 100 000 • Rate of compulsory detention following assessment was 48.6 per 100 000 • 42.6% of assessments were of patients already in psychiatric hospitals **1991** • Of all sections used; s2 58%; s3 37%; s4 4% • Rate of compulsory admissions was 23 per 100 000 • Rate of requests to assess was 83 per 100 000 • Rate of compulsory detention following assessment was 52.9 per 100 000 • 41.4% of assessments were of patients already in psychiatric hospitals • Informal patients referred for assessment fell by 9.7% • S5 patients referred for assessment rose by 32.4% **Over 75's** • Between 1990-91 there was a 31% increase in assessments and 29% increase in detentions • Assessments of those living alone decreased by 12.6%; of those in a staffed unit increased by 11.6%; of those living with relatives increased by 3.9% • In both years, Affectice psychosis was the more common diagnosis.
Huxley, P. and Kerfoot, M.. 1993	A national survey of 82 local authorities (10372 assessments) examining variations in the rates of requests for emergency admission during 1991. Includes data on Ss2, 3 and 4.	• 3873 were requests for S2; 2326 for S3; 520 for S4. • The number of available ASWs in an area was significantly associated with the number of requests for assessment for S2 and S3. • Since 1986, requests for S4 decreased from 29% to 8%. • The number of requests for S2 has remained stable. • The number of requests for S3 are nearly three times as frequent.

Table 3.6 (continued) All of Part II

Author and Year	Background	Main findings
Johnson, S.; Ramsay, R.; Thornicroft, G.; Brooks, L.; Lelliot, P.; Peck, E.; Smith, H.; Chisholm, D.; Audini, B.; Knapp, M., and Goldberg, D. 1997	An in-depth investigation of inner London Mental Health Services.	• Authors present a brief table which shows inner London deviates from the rest of the country most markedly in terms of its compulsory admission rates.
Mortimer, A. M. 1990	An examination of 200 periods of detention (either Ss 2, 3 or 4); 100 in 1983 at the Act's inception and 100 in 1987/88. The aim was to describe any changes in practice in a particular region during this period. Study which shows some interesting though non-significant changes in the use of the Act in one area. There was a lack of information available from many of the case-notes.	• Use of the Act not found to have changed much over the 4 year period. • S4 use was high but dropped from 48% to 27%. • Conversions from S4 rose from 29% to 41%. • S2 use fell from 60% to 51%. • S3 use rose from 26% to 38%(non-significant). • In 20% of cases, S3 lasted for less than 28 days, rising to 36% in 1987/8. • Patients staying voluntarily after expiry of their section dropped from 55% to 40%.
Nasser, M.; Hunt, A., and Walker, T. 1993	A newsletter report on the workings of a Lincolnshire MHA monitoring group. Some brief findings in relation to Sections 5(2), 4 and 136 are reported. Focus of article was the workings of such a group and how it can be beneficial in improving the use of the Act. Figures provided as examples only.	• A policy was prepared to overcome difficulties in the application of S136; this resulted in a reduction in the number of S136 over one year. • There is a general downward trend in the use of S4 and an audit succeeded reducing the rate of inappropriate use of S4. • There is a steady increase in the use of S5(2) which is being closely monitored.
O'Dwyer, J. M. and Mann, B. S. 1989	Case-note review of 40 patients admitted over two years. The aim was to provide a demographic summary of the patient group specific to the moderately secure locked ward in a district general hospital, but paper focuses on the financial aspects of such a unit and its need within the current mental health system. Study does not provide original data, only percentages. Methodology unclear. Little information on factors affecting the patients stay and/or MHA status.	• Almost 70% were male; 90% were unemployed; 80% single. • Diagnoses: 57% diagnosed as schizophrenic; 22% organic psychosis; 16% PD. • 22% were on S2; 45% on S3; 6% informal. • NHS accounted for 67% of referrals; Penal system for 22%; Special Hospitals for 8% and Community agencies 3%. • 57% had previous convictions. • In 62% of cases, a previous conviction was the precipitating cause for admission. • 27% had a history of destructive behaviour; 13.5% had committed minor offences. • 50% of those with psychosis had previous convictions. • 80% of those with personality disorder had previous convictions. • Discharge rate of 70%; equally discharged to the community or less secure settings.

Puri, B. K. and Bermingham, D. F. 1990	Pilot study of differences between S2 and S4 patients in an unspecified hospital. 75 patients' case-notes were reviewed. See main study (Puri, Rose & Bermingham 1992) for more specific results.	• 50% of patients were converted from S4 to S2; 50% from S4 to informal. • 73% had previous admissions. • 12 stayed less than 6 months. • Patients detained under S2 and S4 were more likely to be prescribed neuroleptics and lithium compared to informal patients who were more likely to be prescribed antidepressants and benzodiazepines or nothing. • 58% of S4 compared to 72% of informal patients were followed up as outpatients.

Table 3.6 (continued) All of Part II

Author and Year	Background	Main findings
Puri, B. K.; Rose, G., and Bermingham, D. 1992	All patients admitted under S2 or S4 over a two year perio a random sample of 25 informal admissions in Cambridge. notes were studied (n = 215) in relation to MHA. Concerns S4 use was high. Good comparison of demographic differences between S2 and S4 admissions but main focus of paper appeared to be in justifying high rates of S4 admissions which were seen to be accounted for by the low number of S136 applied in the area. It goes some way in explaining why Cambridge may be different to more urban areas but does not attempt to explain why there remains a reluctance in Cambridge for doctors to admit on S2 or S3 rather than S4.	• Male to female ratio: 1 to 1.7 for S2; 1 to 1.8 for S4; 1 to 1.8 for informal. • 8% of S2 admissions were converted to S3 and 87% to informal status. • 33% S4 converted to S2, 14% to S3 and 46% converted to informal. • Of 96 S2 admissions, there were 109 previous compulsory admissions. • Of 63 S4 admissions there were 72 previous compulsory admissions. • Of the 25 informal admissions there were 7 previous compulsory admissions. • Majority of S2 & S4 & regraded S4 stayed in hospital less than or equal to 6 months. • Informal stayed mostly less than or equal to one month. • Majority of S2, S4 and informal attended outpatient appointments. • 17% of S2, 15% of S4 and 16% of informal were lost to follow-up. • Majority of all groups diagnosed as having mood disorders.
Sheppard, M. 1991	9 ASWs were interviewed regarding requests for assessment for compulsory admission they had received over one year. 3 different referral sources were compared in light of the process of assessment and the outcome.	• Majority of requests for assessment were general; S3 requests occurred more than S2.s. • Males referred by: Medical agency 28%; Informal Network 35%; Agency 51%. • Females referred by: Medical agency 72%; Informal Network 65%; Agency 49%. • Majority of all referrals were unemployed from all referral sources. • Majority of informal and agency referrals did not suggest a psychiatric state (diagnosis), only doctors were found to give a precise suggestion of mental health state. • Medical referrals were significantly less likely to be compulsorily admitted. • If a precise section requested, patient much more likely to be compulsorily admitted. • 90% admitted compulsorily vs 45% not admitted compulsorily.had psychotic problems
Webster, L.; Dean, C., and Kessel, N. 1987	13 hospitals' discharges (6637) were examined over two years to investigate changes as a result of the implementation of Part II of the 1983 Act. 15% of these had been detained under Sections 2, 3, 4, 5(4) or 5(2) at some point during their admission.	• The majority of S5(4) were converted to informal (54%). • 34% of S5(4) were converted to S2. • S2 was used 6.7% of the time in 1959 Act; 6.2% of the time in 1983 Act. • S3 rose from 1.8% of cases to 3% of cases. • S4 declined from 3.2% to 1.6%. • S5(2) increased from 3.2% to 3.8%. • The number of compulsory admissions to large psychiatric hospitals declined significantly from 16.4% to 11.7% during this period. • The number of MHRT hearings rose from 23 to 183 although they always resulted in few discharges both before and after the introduction of the Act.

		- 15% of discharges had been detained at some time during their admission.
Winterson, M. J. and Barraclough, B. M. 1984	Letter detailing a case-note audit of 233 patients in a general hospital detained under Part II of the Act. Limited data, but further data provided below (Winterson & Barraclough 1985).	• S2 admissions rose from 26 in 1981/2 to 36 in 1983/4. • S3 admissions declined from 33 in 1981/2 to 9 in 1983/4. • S4 admissions declined from 19 to 4 over same period.
Winterson, M. J. and Barraclough, B. M. 1985	A further years data in a letter on 585 patients detained under Part II. Shows research following new legislation is not necessarily a good predictor of future practice.	• S2 admissions rose from 56 in 1981/2 to 89 in 1984/5. • S3 admissions declined from 66 in 1981/2 to 18 in 1984/5. • S4 admissions declined from 36 to 17.

2.3.3 Future research into Part II

The majority of the studies presented here generally involved small sample sizes, short study periods and a lack of methodological information. They were often opportunistic, reporting on 'detained' patients or the use of several sections at once, thereby limiting our understanding of the factors affecting the use of different sections under Part II. A better understanding of these factors could be provided. More extensive audits might address psychiatric and demographic details and outcomes of patients detained under different sections in different settings and in different areas addressing social, medical and legal perspectives. In addition, the impact of availability of facilities and resources on the implementation of different sections, the role of speed of assessment, the reasons for, and outcomes of lapsed sections all deserve further attention. Similarly, a more comprehensive and exhaustive approach to examining rates of appeal in different groups of patients would allow further investigation of the factors affecting appeals. Such information would also be valuable in terms of assessing their appropriateness.

Training of relevant professionals, particularly junior doctors and nurses, was a recurring issue in the literature. Training was specifically mentioned in relation to the reasons for nurses' infrequent application of Section 5(4). An examination of influences on their reluctance to apply the section, including their knowledge of, and access to information surrounding Section 5(4) would contribute much to establishing uses of this aspect of mental health legislation.

Finally, research into the capacity of patients to make decisions would be especially valuable. This could involve quite simplistic approaches that could be pursued within a clinical audit, such as examining whether notes contain information suggested by the Code of Practice.

Part 2: Chapter 4 – Part III of the Mental Health Act (1983)

2.4.1 Introduction

Part III of the Mental Health Act (1983) caters for mentally disordered people in the criminal justice system of England and Wales. It provides for remand to hospital for reports (under Section 35) or treatment (Section 36); hospital, guardianship and place of safety orders (Section 37); restriction orders and restriction directions (Sections 41 and 49) and the removal to hospital of sentenced and un-sentenced prisoners (Sections 47 and 48). The number of orders made under Part III of the Act increased from 1,389 in 1984 to 2,018 in 1996. Most of the papers did not directly address the issue of how the Act is used, nor do they present clear distinctions in the use of various sections. They addressed instead the issue of collaboration between the Health Service and the criminal justice system.

2.4.2 Results

Twenty-three articles related to Part III. These are presented in table 4.1. Most of the articles described the way the Act is used in court, prisons and in secure hospitals with an emphasis on the use of remand sections (see table 1). Socio-demographic characteristics were also commonly described using information obtained from patient records. However, 20% of the articles used structured or semi-structured interviews. The findings are discussed in relation to the problems of assessment and transfer under Part III; the demographic differences and variations in use; and the problems associated with the facilities commonly associated with Part III use.

(i) Assessment and transfer under Part III

Many mentally disordered people are being assessed (Grounds, 1988), treated, or simply ignored in prison (Gunn et al, 1991). This is the result, not of the limitations of the legislative framework, but of inadequate resources. There is concern that reception screening by the prison service is neither sensitive nor specific in detecting mental disorder. The incentive and ability to improve matters is reduced owing to a lack of experienced staff, time constraints and a highly mobile population (Birmingham et al, 1996). Additionally, treatment options are limited and prisoners, with personality disorder or sexual deviancy in particular, failed to reach hospital because of disagreements between doctors over treatability and security of facilities (Gunn et al, 1991).

The psychiatric assessment of remand prisoners is often subject to delay. In fact Robertson et al (1994) showed that half of the prisoners studied were disposed of by the courts before a visit by a psychiatrist could be arranged. Transfers to prison and delays in NHS response (with one hospital refusing to consider any admissions from prison) accounted for some of these cases. This is thought to occur because patients are secure, if not safe, being locked up. Imprisonment seems to remove the sense of urgency and is in marked contrast to the time periods in civil procedures for compulsory admissions. Unfortunately, men not referred for outside assessment spent the least time in prison and those accepted for a bed the longest, this leads to a concern over those who may be very ill but asymptomatic during remand, thus escaping medical notice (Robertson et al, 1994).

Reported figures from the Home Office suggested a rapid rise in the number of Section 47 transfers since 1983 (Huckle 1997), this may reflect heightened awareness and an increase in prison medical officers referring the mentally ill (Huws et al 1997). On the other hand the transfer of mentally ill prisoners under Section 47 was characterised by unacceptable delays (Hargreaves 1997; Huws et al 1997) with considerable regional and inter-regional variations. It is possible that these variations reflect doctors' preferences for using 'non-urgent' sections of the Act (Exworthy et al 1992; Anderson & Parrot 1995). Unfortunately one study suggests that, where transfer is slow, suicide rates in prison rise (Huckle 1997). Although those transferred toward the end of their sentence did have shorter sentences, their length of stay in hospital did not differ. There was little evidence that the Section 47 transfer was used to lengthen a sentence and no evidence that the time spent in hospital reflected the gravity of the offence (Huws et al 1997). The need to expedite treatment in advance of the earliest date of release may lead to priority being afforded those with fixed sentences (Hargreaves 1997).

In reality it is felt that many patients subject to Sections 47 and 48 could be managed within general psychiatric services (Anderson & Parrot, 1995; Huckle 1997) particularly if a re-examination of the scope of transfer provision took place (Hargreaves et al 1997). Huws et al (1997) suggest a hybrid order as a solution to improving acceptance of Section 47 prisoners by hospitals. It should be possible for remanded and sentenced prisoners to be transferred to hospital for assessment as well as for treatment under the provisions of Sections 47 and 48 (Robertson et al, 1994). Data show 20% of defendants referred to the court liaison service are later committed to stand trial in Crown Court. A proportion of these could have benefited from the urgent treatment provision of Section 48 (Exworthy et al, 1992), and it has been suggested that Section 48 is underused. The fact that Magistrate Courts play no part in the implementation of Section 48 but must authorise its termination also needs addressing.

Any revisions of MHA provisions for assessment and treatment of mentally disordered remand prisoners should aim to facilitate effective uninterrupted care (Akinkunmi & Murray 1997). More liaison schemes are considered necessary in the effective provision of resources and services required by mentally ill offenders (Birmingham et al 1996; Hajioff 1989; Joseph & Potter 1990; O'Grady et al 1992; Pierzchniack et al, 1997) as they are beneficial in reducing the time between arrest and admission as well as reducing the number of days in custody whether the patient was sent to hospital or not (James & Hamilton 1991). Hospital beds are provided for Part II orders on the day they are made, this is not necessarily the case for Part III unless they are approached by a liaison scheme (James & Hamilton 1991). Other studies have found that special panels of professionals and court diversion schemes can reduce waiting times for the assessment and transfer of mentally disordered offenders and improve outcomes (Hajioff 1989; Joseph & Potter 1990; Pierzchniack et al, 1997).

(ii) Demographics and variations in the use of Part III

Studies of demographic details revealed that the Afro-Caribbean population were over-represented among prison transfers when compared with the prison population as a whole (Anderson & Parrott, 1995). There was also a disproportionately high incidence of paranoid psychotic illness (Anderson & Parrott, 1995) and of those detained under Section 47, significantly more non-white patients are given a diagnosis of psychotic illness as opposed to personality disorder (Huws et al, 1997). However, Brooke et al (1996) found no difference in the length of stay between psychotic and non-psychotic prisoners.

The proportion of people receiving a restriction order compared to the number of guilty indictable crime is barely measurable, the only effect of the new Act seemed to be the rise in unrestricted orders being made (Robertson 1989). As expected more violent offences were committed amongst the restricted population compared to unrestricted and significantly less females were found to be subject to restriction orders (Robertson 1989). Romilly et al (1997) found that the majority of time limited restriction orders were being imposed to serve a tariff-based punitive function. This is contrary to recommendations by the Butler Report which suggest limited duration restriction orders should be confined to cases where there is medical evidence that the offender will recover and cease to pose a danger within a specified period of time.

The six month assessment period in special hospitals was criticised for its inadequacy in assessing psychopathy. However, Section 38 was considered beneficial in assessing the treatability of

psychopathic disorder offences; assuming a hospital order is a measure of appropriate use of Section 38, Kaul (1994) found that the majority of sections were applied appropriately.

Figures suggest that Sections 35 and 36 are leading to more hospital orders being made (Grounds 1988). The use of Sections 35 and 36 appears to have become interchangeable through a gradual process of parliamentary legislation leading to a call to have the sections amalgamated to avoid the use of professional creativity (Fennel 1991).

The use of civil sections such as Section 2 or 3 for remand prisoners, and Section 4 by the Home Office was recommended to address the illogicality of imposing restrictions upon Sections 35, 36 and 38 regardless of the nature of the offence (Akinkunmi & Murray, 1997). Fennel (1991), on the other hand, warned against any double detentions under the Act (i.e. being subject to a section under Parts II and III of the Act) as it raises issues of civil liberties.

(iii) Facilities in the use of Part III

Since 1970, Special Hospitals have accounted for more than half of restricted patients. This is thought to be due to the feeling that local hospitals are not equipped to deal with such patients following an enquiry by the Aarvold Committee (Robertson, 1989). An increase in the number of Special Care Units (SCUs) would relieve the current pressure on beds (Birmingham et al 1996; Naismith & Coldwell 1990; O'Grady 1990) and Regional Secure Units (RSUs) - which in turn take more patients destined for Special Hospitals (Naismith and Coldwell, 1990) - as well as improve waiting times for the admission of prisoners (O, Grady 1990). O'Grady et al (1992) stressed the importance of the mutual dependency between SCUs, RSUs and Special Hospitals. However, concentrating expertise in specialist units can rob other units of expertise and willingness to treat disturbed patients (O'Grady, 1990).

Much of the research identified the need for increased resources such as more secure NHS beds and psychiatric input into prison health services (Brooke et al, 1996) as well as the expansion of secure facilities offering long-term care (Hargreaves, 1997). One study voiced concern over the lack of suitable facilities for mentally ill patients with mild and borderline intelligence (Hoare & O'Brien 1991).

2.4.3 Future research into Part III

Two shortcomings emerge from the body of research into Part III of the MHA. First, most research has been opportunistic with study questions arising from the available data. For example, one area of investigation has been factors influencing whether or not a mentally ill person is moved from prison to hospital. Legislation is only one factor potentially influencing this process and the data here suggest that it might be one of the less important ones. Any examination of the use of the Act as a whole, of its use in different areas and settings, or trends in the use of individual sections over time is likely to describe the reactions of clinicians to shortages of resources. Research into Part III will have to become more clinically driven if anything is to be learned regarding the appropriateness of the legislation itself.

Secondly, there is an almost exclusive emphasis on quantitative methodology. Quantitative methodology alone will never be able to answer questions regarding the appropriateness of present legislation. There is a need for a combination of qualitative and quantitative approaches to examine the use of the Act by professionals and the experience of patients before any overall conclusions regarding the appropriateness of present legislation can be drawn.

Finally, the *Bournewood* judgement and subsequent comments by the government's Mental Health Act Scoping Review Team suggest that any new legislation could be based around patient capacity. The prospect of capacity-based legislation has particular relevance to Part III, since it raises issues around securing public protection once a patient regains capacity to make decisions, thereby ceasing to be liable to formal detention. The concept of patient capacity in relation to mental health requires careful definition before being applied in legislation.

Table 4.1: Part III of the MHA

Author and Year	Background	Main Findings
Anderson, J.B. & Parrott, J. 1995	S.48 transfers from Belmarsh prison were examined using a retrospective case-note analysis of 22 prisoners and a postal questionnaire to the consultant involved. The paper describes the experience of the receiving hospitals, the outcome of the cases and identifies operational difficulties.	• Nature of offence: murder, 13.6%; attempted murder, 9%; rape 4.5%; GBH 9%; ABH 22.7%; theft/robbery 18.2%; armed robbery 4.5%; criminal damage 9%. • 63.6% were detained on a locked ward of a hospital, 22.7% in a RSU, 13.6% in a maximum security hospital. • Reasons for transfer to hospital: serious disturbance/violent behaviour 55%, suicide risk 23%, self-starvation 18%, 1 case suspected organic psychosis. • Most illness was identified because of disturbed behaviour on house block. • 18% identified as ill at reception/police warned that the prisoner was ill. • Average time between assessment and transfer was 2.4 days. • Mean length of stay for hospital admissions was 3.7 months. • 55% diagnosed as schizophrenic. • 70% had a previous history of psychiatric illness. • The diagnosis was revised in 18% of cases. • In only one case was the urgent transfer considered unnecessary. • Home Office rapid and unobstructive following recommendations for transfer. • In 22.7% of cases, clinicians felt patients could have been managed in less secure settings than required by the restriction order. • In 22.7% of cases, restriction order seen to prolong duration of stay in hospital. • 80% of transfer group were Afro-Caribbean.
Bartlett, A. 1993	Literature review on Special Hospitals which contains some reference to Part III. Sources include professional, lay and official accounts.	• 77% of admissions to Special Hospitals in 1990 came from the courts. • A report in 1991 showed that, of the resident population, 61% were detained under the MHA mental illness category. • The majority detained were under 40 years of age. • Evidence suggests that patients grouped under the MHA diagnosis of psychopathic disorder stay longer in hospital. • Delays in transfer are occurring for a high number of patients and the introduction of 597 medium secure beds since 1975 seems to have done little to resolve this delay. • One study suggests 35-50% of existing patients do not require high security.

Table 4.1 (continued): Part III of the MHA

Author and Year	Background	Main Findings
Birmingham, L., Mason, D. & Grubin, D. 1996	The aims were to: define the prevalence of mental disorder and the need for psychiatric treatment in new remand prisoners and to measure the extent to which these were recognised in prison. All men remanded over six month period were approached for interview (n=528) using a semi-structured interview schedule which included: SADS, CAGE, severity of dependence questionnaire and quick IQ test. No specific section of the Act was highlighted.	• Offence committed ranged from dishonesty 48%, violence 39%, sexual offence 5%, homicide 3%, arson 2% and no information 3%. • 68% did not require transfer. • 17% required a general and psychiatric assessment, 3% a specialist psychiatric assessment, 5% management on a hospital wing, 3% transfer to psychiatric hospital. • Average IQ score was 83.4, range 45-120. • Age range 21-70 years; mean 28 years. • 95% were white, 1% Asian, 1% afro-Caribbean. • 63% were unemployed. • 6% diagnosed as personality disorder, 4% as schizophrenia and other psychotic disorders. • 88% had IQ score below population mean. • Mental disorder was present at reception in 26% of cases. Of those the screening process identified mental illness in only 23%. • 16 acutely psychotic men were placed in ordinary cells.
Brooke, D., Taylor, C., Gunn, G. & Maden, A. 1996	A stratified random sample of 750 remand prisoners from 13 prisons was examined using a semi-structured interview and case-note review. The interview had an inter-observer reliability of 90%. The whole sample constituted 9.4% of male convicted prisoners and a 10% sample from each Home Office defined geographical directorate. The study aimed to describe the point prevalence of psychiatric disorder in remand population of England and Wales and to provide an assessment of their immediate treatment need.	• 55% were judged to require immediate treatment: 17% recommended for treatment in prison health services, 9% in an NHS bed, 14% for assessment for a therapeutic community, 15% motivational interviewing for substance misuse, 45% for no treatment. • Age range from 16 - 60.8 years, mean 27.5 years. • Median length of stay was 64 days, 1-1501 being the range. • Psychiatric disorder diagnosed in 63% of subjects: 11.2% personality disorder, 18% neurotic disorder, 4.8% as psychotic condition, 38% alcohol/drug dependency, 37.4% as no diagnosis. • Small number of psychotic diagnoses is related to the high number of psychotic subjects who were unable to tolerate the interview. • Of those requiring transfer: 64 (50%) required medium security, 3% maximum security and the rest a normal hospital.
Exworthy, T., Parrott, J.M. & Bridges, P.K. 1992	Case study to illustrate the under-use of Section 48.	• S48 had to be used in this case where a defendant required psychiatric treatment, since case could only be tried in Crown Court, thus S35 unavailable. • S36 may have been more appropriate but person would have had to go to court first. • As the charge could not be reduced, civil sections and S37 also

		unavailable. • A retrospective analysis of defendants referred to psychiatrists suggests this scenario is not unique and yet S48 continues to be used sparingly.

Table 4.1 (continued): Part III of the MHA

Author and Year	Background	Main Findings
Fennell, P. 1991	Not data based, this is a presentation of a debate on the legalities and morality of "double detention" under the MHA. However, the report does present data from another study.	• Figures from another study suggest that use of S36 use rose from 6 cases in 1984 to 34 in 1988/9 for England and Wales. • S35 use rose from 162 to 328 over same period. • A fall in the number of psychiatric reports over the same period calls into question the success of S35.
Grounds, A. 1988	Aimed to determine whether (then) new powers for courts under Ss35 and 36 to remand mentally disordered offenders to hospital resulted in a reduction in the numbers held on remand. Home Office, DHSS statistics, reports by prison medical officers and admissions to hospital were examined for 1983-1985.	• The number of defendants in custody on whom reports were prepared did not change. • Hospital orders at sentencing went from 8.7% in 1983 to 8.6% in 1985. • Admissions under S35 and S36 (new remand sections) totalled 178 in 1985. • A 15% reduction in the number of prison medical officer recommendations suggests a shift towards the NHS as a source for such opinions.
Gunn, J., Maden, A. & Swinton, M. 1991	Study of 5% of male prison population in order to assess their psychiatric and treatment needs using a semi-structured interview of prisoners and their case- notes.	• Reasons for detention: violence 22%; burglary 21%; theft 18%; robbery 14%; drugs 10%; sexual 9%. • 55% held in training prison, 33% in local and 12% in open. • 16% non-white. • Majority (37%) had sentence of 18-47 months. • Diagnosis: 1% diagnosed as schizophrenic, 10% as personality disorder (74% of whom required psychiatric treatment), 11.5% as alcohol dependent, 11.5% as drug dependent, 63% were not diagnosed as mentally ill. • 12 of the 37 who were thought to require in-patient psychiatric treatment had developed their illness after imprisonment. • The other 25 had been ill at time of offence. 24 of these were known to psychiatric services. • At trial, 18 had been judged unsuitable for treatment in hospital because of difficult or violent behaviour!

Table 4.1 (continued): Part III of the MHA

Author and Year	Background	Main Findings
Hargreaves, D. 1997	The use of S47 to transfer to hospital prisoners with mental illness was investigated by case note review and clinical interview. Subjects satisfied ICD-10 criteria for schizophrenia, delusional disorder and major affective disorder. 21 prisoners were identified of whom 17 had been subject to transfer. Study considered extent of psychopathology, duration of illness and anticipated level of hospital security in the transfer of such prisoners.	• 11 life sentences, 10 determinate. • 55.5% of offences committed were serious sexual offences • 18.5% were for violent offences, 3/27 for murder. • 38% illnesses identified at initial reception (waited from 1-14 days for assessment), 57% by prison staff, and 1 self-presented (waited for 6-390 days for assessment). • Time between assessment and transfer variable. • Range of prison sentence was 5-14 years. • Age 23-57 years. • 95% white, 5% afro-Caribbean. • 85.7% had previous convictions, 1 previous disposal to special hospital. • 23.8% previous admissions: 60% of which held in secure hospitals. • 80.9% schizophrenic. • 11/17 (64.7%) accepted for transfer; 45.5% going to a special hospital, 45.5% to a regional secure unit and 1 to a local secure unit. • Reasons for request for transfer were: 30.8% behavioural disturbance, 30.4% non-compliance with treatment, 13% self-harm with the rest divided between assaults on staff, fire setting, food refusal and disabling negative symptoms. • Causes of delay between referral and assessment are not apparent but some cases were because of diagnostic doubt by prison officers. • Those rejected after request for transfer showed greater chronicity by the time of the first referral. • 8 of the 9 cases initially rejected for transfer were serving life sentences.
Hoare, S. & O'Brien, G. 1991	An audit of all offenders admitted to an interim secure unit for the mentally handicapped under Ss35 and 37 (n=38) over a ten year period. The aim was to assess the effect of the 1983 Act on admission practices. Data from 5 years pre and 5 years post the Act were compared. A pre-coded structured schedule was used to collect data.	• 27 were admitted under 1959 Act, 11 under 1983. • Most common reason for detention, under each of the two Acts, was theft and criminal damage. • 79% had previously been hospitalised. • 16% had additional diagnosis of psychopathic disorder, 2 were diagnosed as psychopathic with no mental handicap diagnosis. • 95% were diagnosed as having mental impairment or subnormality. • Nearly half of both groups were under 21yrs. • IQ scores, age and offence were similar for the 2 groups.

		• 97% had been convicted of previous offences. • No women were admitted following the 1983 Act. • Compulsory admissions fell by over half during ten year period.

Table 4.1 (continued): Part III of the MHA

Author and Year	Background	Main Findings
Huckle, P.L. 1997	Retrospective analysis of the case notes of 25 prisoners who were subject to S47 transfer over three years (1992-95). The aim was to assess whether mental illness was being missed at the initial screening assessment at magistrates court.	• Reasons for arrest: 13 for burglary, 7 for robbery, 3 for murder, 2 for arson, the rest for deception, sexual, assault, criminal damage or dangerous driving. • 41% transferred to psychiatric ward, 31% medium secure provisions, 21% to private psychiatric care, 6% to maximum security. • Reasons for transfer: 41% psychotic and distressed, 31% possible suicide, 14% assaultive to others, 10.3% depressed / poor fluid intake, 3.5% suicide attempt. • Outcome following treatment: 44% returned to prison, 28% remained in hospital, 14% each transferred to lower secure conditions or discharged to community. • Within 3 years, 20% re-convicted and 23% re-admitted to hospital. • 20-55yrs old, White 22, Afro-Caribbean 1, Arab 2. • 57% had previous psychiatric treatment, 35% had previously been admitted under a civil section of the MHA, 50% diagnosed as schizophrenic. • One inmate was transferred in serious psychotic state when court ignored medical recommendation for hospital order.
Huws, R., Longson, D., Reiss, D. & Larkin, E. 1997	Analysis of 351 case notes of prisoners transferred under S47 to Special Hospitals between 1984 and 1991. Demographic details of cases and outcomes are presented.	• 49% transferred to Ashworth, 26.8% to Rampton and 24.2% to Broadmoor. • 96% of transfers subject to s.49 restriction. • Reasons for transfer were 80% presence of mental disorder, 9% dangerous/violent behaviour, 6% concern about release, 3% following request for assessment by judge and 2% unclear. • Following treatment, 56% were discharged: 60% returned to prison, 39% discharged to local hospital or community. • Average waiting time for assessment was 1.7yrs. • Waiting time between assessment and transfer 3.7yrs average (waiting for HO to approve). • 14% of white and 1% of non-white admissions were female. • 30% of white and 63% of non-white admissions were schizophrenic. • Of the transfers discharged to local hospital or community, 39% were serving life sentences. • 44% of determinate sentence prisoners were detained after their latest date of release.

		• Of the 21 prisoners transferred due to concerns over their release, only 5 had a mental illness. • Average time from request for opinion to transfer was less than 2 months.

Table 4.1 (continued): Part III of the MHA

Author and Year	Background	Main Findings
James, D.V. & Hamilton, L.W. 1991	A nine month prospective study of 1014 court referrals and prison records which aimed to determine the efficacy and cost of psychiatric liaison schemes to magistrates' courts. Outcome measure: shortening the period spent in custody on remand. Compared remand prisoners assessed through liaison schemes with prisoners subject to hospital orders who had been assessed using a traditional manner of referral.	• Offence committed was similar for both groups with thefts, assault and criminal damage being most frequent. • Mean number of days between referral and assessment was 15.1 for prison group, 0 for liaison group. • Mean number of days between assessment and transfer was 50.8 for prison and 8.7 for liaison. Difference statistically significant. • Of the 39 cases where Act applied, 64% made subject to S2 or 3 & 36% S37. • 84% of prison and 82% of liaison groups had previous criminal record. • 72% of prison and 73% of liaison group had previous psychiatric admission. • 82% prison and 88% liaison group diagnosed as schizophrenic.
Joseph, P.L. & Potter, M. 1990	Examination of new court-based psychiatric service providing psychiatric assessments of the homeless mentally ill with the intention of diverting from custody those awaiting assessment. Study examines 80 defendants using a semi-structured interview. No specific sections of the Act are examined.	• Majority arrested for public order offences (35%) followed by theft (16%) and criminal damage (14%). • Medical recommendations: 36% none; 26% psychiatric outpatients; 15% S2; 8% S35; 6% informal admission to hospital; 5% bail to hospital; 2% probation and outpatients; 1% S3 and 1% S37. • 48% schizophrenic, 10% personality disorder, 5% no mental disorder. • 36% admitted directly to hospital either informally or under the Act. • 77% had previous psychiatric admission, majority under the Act. • 30% of those admitted to hospital informally or under the Act had their cases discontinued by CPS. • 35% discontinuance rate using the scheme compared to usual rate of 1-2%.
Kaul, A. 1994	Aimed to examine the frequent use of S38 in one Regional Secure Unit. Retrospective case study for year 1988. Of 32 admissions, 11 were under S38.	• 8 S3; 1 S35; 2 S36; 6 S37; 6 S48; 1 Ss37/41. • 2 groups of patients identified at RSU: 1, non-offenders difficult to manage in hospital & mentally abnormal offenders admitted under Part III (29.8% S38). • S38 significantly more likely to have a poor employment record. • Majority of S38 offenders had never been admitted to a psychiatric hospital, were suffering from psychopathic disorder, were significantly more prone to drug and alcohol use problems, were significantly younger when started criminal career and more likely to have committed acquisitive offences. • Average 13.8 weeks spent on S38.

		• 6/11 S38 were converted which could suggest appropriate use.

Table 4.1 (continued): Part III of the MHA

Author and Year	Background	Main Findings
Lock, M. 1997	A letter in response to Akinkunmi & Murray (1997) which illustrates an anomaly within S48 by detailing the case study of a serious offender	• Admission arranged under Ss48/49 for assessment & treatment of depression. • After treatment under the Act, police concerned he would be a security risk if released; arranged to transfer back to remand prison. HO stated that prisoner could not have Section terminated until authorised by magistrates court. • Highlights anomaly in Magistrates Court which does not play a role in the implementation of S48 but must authorise its termination • Questions why HO cannot authorise a transfer back to prison.
Naismith, L.J. & Coldwell, J.B. 1990	Retrospective study of all admissions over a two year period to Park Lane Special Hospital (1987/8). By describing and comparing with an earlier study, the authors aimed to examine the effects of the introduction of the 1983 Act and the influence of the development of RSUs. 109 patients' case notes and admission figures were reviewed. Areas of the Act covered include: Ss35, 37, 37/41, 38, 47/49, 48/49, Part II.	Section used: • 1959 Act: S37(41): 57%; S37: 6%; S47/49: 22%; S48/49: 3%; S3: 5% • 1983 Act: S37(41) 37%; S37: 5%;S47(49): 27%; S48/49 6%; S3 8%; S35: 9%; S38: 4% . Offence committed: • 1959 Act: Other violence, 28%; manslaughter 14%; malicious damage 11%; sexual offence 10%; attempted murder 10%; property offence 9%; murder 8%; no criminal charge 5%. • 1983 Act: Other violence, 39%; manslaughter 16%; malicious damage 7%; sexual offence 11%; attempted murder 4%; property offence 2%; murder 14%; no criminal charge 7%. Referral source: • 1959 Act: court 58%; prison 21%; NHS/RSU 13%; Special Hospital 1%; Community 6%. • 1983 Act: court 30%; prison 36%; NHS/RSU 26%; Special Hospital 6%; Community 2%. Previous institutional care: • 1959 Act: None 7%; Children's home 27%; penal system 66%. • 1983 Act: None 53%; Children's home 15%; penal system 32%. • Majority aged 30-39yrs, 30% under 1959 Act. • Majority aged 20-29yrs, 40% under 1983 Act. • Mean age under 1959 Act 30.8yrs and 1983 Act 33.3yrs. Ethnicity: • 1959 Act: White 84%; Asian 3%; Caribbean 10%; African 2%. • 1983 Act: White 85%; Asian 6%; Caribbean 8%; African 1%. Diagnosis:

		• Psychopathic disorder: 1959 Act 20%; 1983 Act 25%. • Schizophrenia: 1959 Act 59%; 1983 Act 72%.

Table 4.1 (continued): Part III of the MHA

Author and Year	Background	Main Findings
O'Grady, J. 1990	This paper aimed to describe the relative contribution of the local and regional secure services in light of a new Special Care Unit (SCU) set up to provide 24 hour back-up to the general psychiatric wards. Aim of the unit is to assist the hospital in treating violent patients safely and humanely. Admission figures for 3 years to the SCU were collected (n=291) and a postal questionnaire of psychiatrists and prison medical staff was used to estimate unmet need.	• Out of 200 admissions: 7 admitted under S35; 8 under S37; 2 under Ss47/48. • Less than 1% moved to RSU & none to Special Hospital during study. • 84% referred from psychiatric beds; 5% from community; 5% from police custody; 6% from prison. • 78% stayed less than one month (38% under one week). • SCU receives majority of admissions compared to RSU thought by psychiatrists to require treatment in secure conditions. • 81% of prison referrals came to SCU, the remaining 19% went to the RSU. • SCU admitted more mentally abnormal offenders than RSU. • Presence of a locked ward allowed for correct use of S35. • A significant number were directed from remand prison by being admitted directly from police custody. • A worrying number stayed in SCU for over 3 years. There was concern that this could split up the service. • Psychiatrists and prison medical staff were satisfied that those requiring treatment in secure conditions were receiving it.
O'Grady, J., Courtney, P., and Cunnane, J. 1992	A case note review of all patients admitted to either a SCU (n=64), RSU (n=26) or a special hospital (n=12), was carried out. Data collected related to socio-demographics as well as clinical and forensic history.	Referral source: • To RSU: Court, prison and special hospitals formed 58%. • To SCU: psychiatric wards, police custody and the community formed 91%. Detentions under the Act: • Part II: SCU 92%; RSU 50%; special hospital 10%. • Part III: SCU 8%; RSU 17%; special hospital 76%. • Criminal Procedure Insanity Act: special hospital 14%. • Restriction orders: SCU 0; RSU 33%, special hospital 57%. • Age range: SCU 23-47 – mean 37 yrs; RSU 19-41 - mean 32 yrs; SH 23-47- mean 41 yrs. • Average length of stay: SCU: 1yr & 4 months, range: 1 day to 5.5yrs; RSU: 5 months, range: 1-12 months; SH: 9yrs 2 months, range - 1 month to 30 years. • Marital status, single: SCU: 83%; RSU: 83%; SH: 76%.

Table 4.1 (continued): Part III of the MHA

Author and Year	Background	Main Findings
Pierzchniack, P., Purchase, N. & Kennedy, H. 1997	114 sets of case notes and papers of prisoners subject to Parts II and III of the Act over one year were examined. The aim of this study was to identify factors causing delay in transfer from prison to more appropriate placements by comparing transfer times for mentally disordered offenders appearing before 13 Magistrates Courts.	• Offence committed: violent 32.1%; sexual 9.8%; robbery 8.9%; criminal damage 11.6%; arson 2.7%. • Time between assessment and transfer: S48 40 days; S37 45 days; S47 85 days; Part II 2 days; Remand (Ss.35, 36, 38) 48 days. • Age: Range: 19-71 years; mean 32 years. • Ethnicity: 43% white and 57% ethnic minorities as a whole. • 71.8% received medication, 19 required forced injection, 55 took voluntarily. • 57.9% schizophrenic; 13.2% paranoid psychosis ; 6.3% other psychosis. • 71.9% had past history of psychiatric treatment.
Robertson, G. 1989	This paper aimed to examine the nature and use of the restricted hospital order S37/41 between 1961 and 1985.	• 16% of all S37 were subject to restrictions. This rose to 20% between 1967-1974 and fell to 15% 1980 onwards. Offences subject to restrictions: • SH: violence 73%; sex 31%; theft 30%; other 55% • Local hospital: violence 27%; sex 69%; theft 70%; other 45% • 26% restricted orders had psychopathic disorder compared to 5.5% of unrestricted orders. Trends in use of Orders: • 1961-70 154-278 restricted; 912-1039 unrestricted. • 1971-81: 232-107 restricted; 953-681 unrestricted. • 1982-85: 143-114 restricted; 612-819 unrestricted. • 47% of all hospital orders made in respect of psychopathic disorder are restricted (mental illness 12.6%; mental impairment 15%). • Male restricted orders vary considerably year on year. • Violent offences account for 55% of restricted population and 17% of unrestricted.

Table 4.1 (continued): Part III of the MHA

Author and Year	Background	Main Findings
Robertson, G., Dell, S., James, K. & Grounds A. 1994	Case notes of referrals to Brixton Prison Medical Service were examined for 5 months in 1989. The authors aimed to describe the process by which mentally disordered remand prisoners are referred for psychiatric assessment. Only those diagnosed as psychotic, mentally handicapped or possibly psychotic were examined in detail (n=336).	• 1961-70 154-278 restricted; 912-1039 unrestricted. • Of those who came to the doctor's attention: 71% did so because a court report had been requested; 21% were referred from reception; 8% from main or other prison. • Reasons for arrest: Other thefts 26%; robbery/burglary 8%; Criminal damage/ vagrancy/ public order 20%; Assault 18%; Serious violence 6%; Sexual 7%. • Disposal of men not referred for 2nd opinion: S37, 5%; Prison, 24%; Non-custodial sentence, 71%. • Disposal of men referred and rejected: S37, 5%; Prison, 20%; Non-custodial sentence, 75%. • Disposal of men referred and not visited: S37, 4%; Prison, 7%; Non-custodial sentence, 89%. • Reasons psychotic men were not referred for a 2nd opinion: No court report requested, 32%; Diagnosis of psychosis changed 21%; Improved mental state 16%; Other reason 13%; Mental handicap diagnosed 11%; Court liaison or other arrangement made 8%. • Outcome following treatment: Returned to prison 44%; Remained in hospital 28%; Transferred to lower security 14%; Discharged to community 14%. • Within 3 years, 20% were re-convicted and 23% re-admitted to hospital. • One doctor was responsible for 20/28 cases where no medical report had been requested. • Of those referred but not visited, over half was because they had been disposed of by courts before visit could be arranged. • Average time between admission and assessment was 4 weeks. • Transfer to prison and delays in NHS response accounted for 35% of cases and were responsible for 90% of people referred but not visited. • Of those rejected at assessment, 81% considered not suffering from psychotic illness or not ill enough to warrant S37. 11.5% due to lack of security. • Authors estimate 12-15% would have been accepted if assessed by a different doctor.

		• Of those offered a bed, 90% were made subject to S37. • Of those not offered a bed, no less than 70% given non-custodial sentence

Table 4.1 (continued): Part III of the MHA

Author and Year	Background	Main Findings
Robertson, G., Dell, S., James, K. & Grounds A. 1994 (Continued)		• 11% psychotic population received prison sentence. • Men not referred for outside assessment spent least time in prison, those accepted for a bed the longest. • Average delay between acceptance for a bed and admission was 6 weeks. • Delay between hospital order and admission was 2 weeks.
Romilly, C., Parrott, J., Carney, P. 1997	Home Office files were reviewed for each case where S41 had been made, between 1983 and 1993. A descriptive and qualitative study examining the use of limited duration restriction orders (Section 41). The authors set out to determine the proportion, number and duration of restriction orders over 10 years whilst detailing demographic characteristics and differences of those subject to Section 41.	• 73 orders were imposed over 10 years, range 3-11 per annum • Mean length of duration for an order was 3.1 years, ranging from 9 months to 7 years • 70% had a mental illness classification • 16.4% categorised as psychopathic disorder • 10 were sent to SH. The remainder were equally divided between RSUs and ordinary district wards Of the offenders: • 84% male • Average age was 33yrs in men, 28 years in women • 6 people were under 28 years of age • Half were given a diagnosis of chizophrenia, 7 other psychotic illnesses, 6 affective disorders, 11 personality disorders, 9 mentally impaired • 83.5% had a past history of mental illness • 2/3 had previous convictions • ½ had previous convictions for serious offences • The majority of offences were 'violence' other than homicide • A psychiatrist specifically recommended a LDRO in only 11 cases • In 30 cases, the psychiatrist did not discuss the RO

Part 2: Chapter 5 - Part X of the Mental Health Act (1983)

2.5.1 Introduction

This chapter assesses the use of Part X of the Mental Health Act (MHA) which gives police the power to remove a person to a place of safety pending an assessment by a doctor and approved social worker (ASW). Part X of the Mental Health Act 1983 comprises Sections 135 and 136. Section 135 provides a warrant to search for and remove a person from a private residence to a place of safety. Section 136 allows removal by police from a public place to a place of safety. The studies identified in this review most often investigate the use of Section 136, occasionally providing data on other sections under Part II of the Act. Only one study has investigated the use of Section 135. This chapter is centred around three main themes arising from the literature. These are:

(i) The characteristics of those detained under Sections 135 and 136.
(ii) Is Section 136 being implemented appropriately?
(iii) Are professional relationships affecting the implementation of Section 136?

2.5.2 Results

Of the 148 relevant articles identified, 29 papers were identified and are discussed in this chapter. On closer examination, 2 papers were found to contain no additional data, and 27 papers are summarised in table 5.1. Section 136 is the most commonly investigated single section of the Act, with studies ranging from 1959 to the present day. Of the papers reviewed here, 2 provide commentary on the use of Section 136; 8 investigate and report professionals attitudes and/or use of Section 136; 14 provide demographic and clinical details of people detained under Section 136; 3 are reviews of studies on Section 136; and one is a case history presentation in support of changes in legislation for Section 135.

(i) Characteristics of those detained under Sections 135 and 136

Many of the findings in these studies mirror those observed in Chapter 2 of this report. Section 136 detentions are more common in urban populations (Berry, 1996; Fahy, 1989; Rogers and Rassaby, 1986b). Section 136 detainees are more likely to be young, male (Dunn & Fahy, 1990; Fahy, 1989; Pipe et al, 1991; Rogers, 1990; Rogers & Faulkner, 1987; Rogers and Rassaby, 1986b; Turner et al, 1992), violent (Dunn & Fahy, 1990) and suffering from schizophrenia (Dunn & Fahy, 1990; Fahy, et al, 1987; Pipe et al, 1991; Rogers & Faulkner, 1987; Spence & McPhillips, 1995). Section 136 detentions are

higher in the black population (Bean et al, 1991; Dunn & Fahy, 1990; Fahy et al, 1987; Pipe et al, 1991; Rogers, 1990; Rogers and Faulkner, 1987; Turner et al, 1992). Rogers and Faulkner (1987) stress that the attitude and perceptions of the person calling the police initially must also be taken into account. Three studies found no differences in outcome between ethnic groups (Bean et al, 1991; Rogers, 1990; Turner et al, 1992) and several authors found no evidence of differences in the behaviour of the police implementing Section 136 towards different ethnic groups (Bean et al, 1991; Fahy et al, 1987; Mokhtar & Hogbin, 1993).

(ii) Is Section 136 implemented appropriately?

There were a high number of Section 136 arrests on private premises (Bean et al 1991; Cherrett 1995) and police were found to be using alternative methods in order to implement Section 136 (Rogers 1990). The 'creative' use of Section 136 in private dwellings is seen as justifiable in light of the uselessness of Section 135 (Cherrett 1995; Cutajar & Hampson 1997; Fahy & Dunn 1987; Rogers 1990; Wallis 1989). There is an overwhelming belief in, and use of, Section 136 as a three day admission section (Bean et al, 1991; Fahy et al, 1987; Latham, 1997; Rassaby & Rogers, 1987; Rogers and Faulkner, 1987; Rogers and Rassaby, 1986b) and the police were considered to be the only 24 hour service available highlighting a distinct lack of voluntary or statutory services out of hours (Berry, 1996).

Alongside these claims of the inappropriate use of Section 136, a number of studies have also reported the police to be correct in most of their decisions to refer people for Section 136 assessment (Andoh, 1994; Dunn & Fahy, 1990; Fahy, 1989; Fahy & Dunn, 1987; Lowe-Ponsford & Begg, 1996; Rogers and Faulkner, 1987; Turner et al, 1992; Weller, 1988). However, this research has highlighted a lack of formal policies surrounding its use (Bean et al, 1991; Fahy & Dunn, 1987; Klijnsma et al, 1994); Mosley, 1997; Shah & Markwick, 1989). Furthermore, a general lack of confidence in dealing with the mentally ill was identified amongst police (Cherrett, 1995; Fahy & Dunn, 1987; Revolving Doors Agency; Shah & Markwick, 1989) with levels of knowledge about Section 136 among Police Surgeons being of some concern (Latham, 1997). These concerns have prompted calls for additional training in the implementation of the Act (Bean et al, 1991; Berry, 1996; Gray et al, 1997; Shah & Markwick, 1989). Clearer policies on Section 136 use and treatment under common law (Bean et al, 1991; Fahy & Dunn, 1987; Rassaby & Rogers, 1987) with particular emphasis on social problems and community care are required (Revolving Doors Agency; Rogers, 1990; Rogers & Faulkner, 1987; Rogers & Rassaby, 1986b; Shah & Markwick, 1989).

It should be noted that the information recorded by the police regarding Section 136 detentions was minimal and could affect the accuracy of observed trends in its use (Berry, 1996; Latham, 1997; Lowe-Ponsford & Begg, 1996; Revolving Doors Agency; Weller et al, 1988). Bluglass is quoted in Wallis (1989) as stating that the over-representation of Section 136 in London is because other areas rarely record its use unless the patient is admitted. Better information systems for the police and other services are required for the recording of Section 136 detentions (Berry, 1996; Fahy, 1989; Gray et al, 1997; Moore & Moore, 1994; Rogers & Faulkner, 1987; Turner et al, 1992). Latham (1997) in particular, suggests a universal Section 136 form for all police services in order to provide centrally held statistics of its use.

(iii) Are professional relationships affecting the implementation?

Poor relations and a generally perceived mistrust between police, psychiatrists and Social Workers was widely reported (Bean et al, 1991; Fahy & Dunn, 1987; Mosley, 1997; Revolving Doors Agency; Rogers, 1990; Shah and Markwick, 1989). Better communication and policies between all three services were advocated (Bean et al, 1991; Fahy et al, 1987; Fahy & Dunn, 1987; Klijnsma et al, 1994; Mokhtar & Hogbin, 1993; Rogers & Faulkner, 1987; Rogers & Rassaby, 1986a; Shah and Markwick, 1989; Turner et al, 1992).

In general, police and psychiatrists perceived a lack of ASW involvement in implementing Section 136, and better monitoring of social worker attendance at assessments was called for (Bean et al, 1991). Limited ASW involvement was often explained in terms of a lack of resources, and was further justified on the grounds that it was not the role of the ASW to provide assessments although this is considered by many to be exactly the role of the ASW (Bean et al, 1991; Fahy & Dunn,1987; Klijnsma et al, 1994; Latham, 1997; Rogers, 1990; Rogers and Faulkner, 1987; Rogers & Rassaby, 1986a; 1986b; Shah & Markwick, 1989; Wallis, 1989). Resource use had an influence on the involvement of all three agencies. For the police, mental health problems and the incidents relating to them often involved non-criminal or minor offences (Bean et al 1991; Berry 1996; Fahy 1989). However, such incidents were found to use more police resources than burglaries, and were seen as diverting police resources away from dealing effectively with criminals (Berry, 1996; Fahy & Dunn, 1987). A number of hospitals were found to be refusing Section 136 referrals on the basis of bed shortages (Bean et al, 1991; Fahy & Dunn, 1987).

The police station was not viewed as a suitable Place of Safety (Cherrret, 1995; Fahy & Dunn, 1987, Latham, 1997). Many authors remarked that the Place of Safety should be clearly designated,

disassociated from formal inpatient facilities, more relaxed, able to provide security and multi-disciplinary assessment and be within easy access of medical facilities (Bean et al 1991; Cherret 1995; Fahy et al 1987; Fahy & Dunn 1987; Latham, 1997; Rassaby & Rogers 1987; Rogers & Faulkner 1987). Specialist Emergency Assessment Units were regarded as better at assessing and providing a wider range of disposals than hospitals (Rassaby & Rogers, 1987; Rogers and Faulkner, 1987).

2.5.3 Future research into Part X

There is a general lack of information surrounding the use of Section 135, possibly as it is rarely used. However, alongside the observation that Section 136 is being used in ways more appropriate to Section 135, this requires further examination. There is a call for further training of Police Surgeons; Latham (1997) suggests that Section 12(2) approval should be a requirement for all doctors undertaking Section 136 assessments. Whilst there is a plethora of literature available on ethnicity and mental health (for example see Nazroo 1997), further research into the over-representation of ethnic and homeless groups specific to detentions under Part X is still needed.

Table 5.1 Part X: Sections 135 & 136

Author and Year	Background	Main findings
Barnes 1990		• Results do not confirm that there is a disproportionate use of S136 within the black population.
Bean, P., Bingley, W., Bynoe, I., Faulkner, A., Rassaby, E. & Rogers, A. 1991	This is a report of Parts 2 and 3 of the MIND study which focuses on police and psychiatrist attitudes, actions and interactions in relation to the use of S136. It is both primary research using data obtained from the police station where the study was based from 79 people subject to S136 and a review of the literature already available.	• 69.6% male; 30.4% female. • Most common causes for detention under S136 were disturbance on the street (21.5%); and 'wandering' (20%). • Following assessment by a doctor, 53% were referred under S136. • 64.5% were under the age of 35 years. • 50.6% were afro-Caribbean.
Berry, R. 1996	Retrospective analysis of police records and section papers of 27 individuals involving 238 incidents of S136. The aim was to assess total police contact with the mentally disordered in Northumbria. The study provides a unique perspective on the use of S136 and raises many issues surrounding resource and training implications.	• There were significantly more contacts on Fridays and at weekends. • All 27 were assessed by the police surgeon, the majority were assessed only once, although 1 person was assessed 12 times. • An average of 2.5 incidents found in rural areas, 22 in semi-rural and 17.6 in urban. • The average man hours spent per incident was 3.2. • 179 incidents were of a non-criminal nature. • Unclear in any of the cases whether the mentally disordered person was a victim, witness or offender in the crime situations.
Cherrett, K. 1995	Semi-structured interview and examination of case-notes and police records in a prospective 3 month study in a police station looking at police use of, and attitudes towards S136. Little information available on the methods or sample size.	• 44% female; 56% male. • Increase of 70% contact between 1992/93 and 1993/94. • 34% officers perceived contact as rising. • 21% felt dealing with mentally ill should not form part of their every day duties. • 38% patrol officers & 94% custody staff felt lacked training to deal with mentally ill. • 75% police officers believe police station to be inappropriate for the assessment of mentally ill (especially when the majority haven't committed a crime). • Psychiatric institutions were found only to assess if the patient was known to them. • 12% were of no fixed abode or transient. • 58% of all mental contacts and 67% of S136 detentions occurred in private dwellings.
Cutajar, P. & Hampson, M. 1997	Presentation of one case history to substantiate authors recommendation that the wording relating to the	• Involves a family who were all potentially unwell with one or members of the family being under 18 years of age.

	implementation of S135 of the Act be changed. Good example of the type of studies missing.	• Under the terms of the Act, the Justice of the Peace cannot grant a warrant for a police constable to enter the property because the Act specifically states that the person in question should be living alone.

Table 5.1 (continued) Part X: Sections 135 & 136

Author and Year	Background	Main findings
Dunn, J. & Fahy, T. 1990	Retrospective case-note examination of 253 patients referred under S136 to a psychiatric hospital in catchment area with large afro-Caribbean population. They aimed to compare differences between black and white referrals and assess police ability to recognise mental disorder.	• Male 62%: Black 20.5%; White 41.5%. • Female 38%: Black 14%; White 24%. Reasons for use of Section: • Black and white females: non-violent behaviour 66% and 45% respectively. • Black and white males: violent behaviour 58% and 49% respectively. • Black males were significantly younger than white males; Black females were younger. Mean 27 and 32 years respectively. • Average number of previous admissions was 3.3 for black population and 3 for white. • Previous admissions under S136: 40% white men; 24% black men; 32% black women; 24% white women. • Detained above 72 hours: 88% black men; 81% black women; 74% white men; 73% white women. • Given neuroleptics: 90% black males; 83% black females; 63% white males; 80% white females. • More blacks and more females were offered follow-up: 48% black males; 71% black females; 25% white males; 58% white females. • Diagnosed as schizophrenic: 44% black males; 50% black females; 21% white males; 25% white females. • No blacks diagnosed with personality disorder. • More black males diagnosed as drug induced psychosis than white counterparts. • 20% white males compared to 0% black males as drug or alcohol dependency. • 10% white females and 0% black males as depression. • 10% of black males compared to 55% white and 0% black females and 8% white females given no diagnosis. • Black group accounts for 15% of catchment area but forms 33% of S136 admissions.

Table 5.1 (continued) Part X: Sections 135 & 136

Author and Year	Background	Main findings
Fahy, T.A., Bermingham, D. & Dunn, J. 1987	Retrospective case note review over two years of one urban and one rural hospital whose Section 136 admissions are higher than the national average. Factors influencing admission were examined. 240 urban, 135 rural and 91 control patients used.	• S136 population: Urban male 70%; female 30%; Rural S136 population: male 56%; female 44%; Control: male 45%; female 55%; England/Wales: male 59%; female 41%. • 77% of urban, 84% of rural and 58% of control sections were applied out of hours. • 28% urban, 19% rural and 59% control were converted to S2. • S136 responsible for 7% of all admissions to urban and 3.9% to rural hospitals. • Urban males mean age 34.6, females 31.9. Rural 33 & 42.6; control was 37.5 & 38.9. • Overall urban age 33.4 years; Afro-Caribbean group 27.2 years. • White UK: Urban 53%; rural 84%; control 47%. • 77% Of urban compared to 84% of rural group had previous admissions. • 36% of urban population compared to 8% of rural had previous S136 admissions. • 90% of urban and rural populations spent less than a week in hospital. • 70% of control, 58% of rural and 39% of urban were offered outpatient follow-up. • 27% urban, 43% control, 32% rural were diagnosed as schizophrenic. • 23% white UK compared to 38% afro-Caribbean were diagnosed as schizophrenic.
Fahy, T.A. & Dunn, J. 1987	This was survey of 184 Metropolitan Police Stations to ascertain police views on use of S136 and their dealings with other services. A potentially revealing study but New Scotland Yard imposed a block on the study and so results are based on the 41 returned questionnaires and so limited by the small sample size. **(See also Dunn, J. & Fahy, T. 1987 with briefer details)**	• 71% felt back-up by medical and social services were inadequate. • 61% felt had insufficient training to deal with mentally ill. • 56% felt that mental hospitals in the area did not provide adequate support. • 66% felt S136 could have been avoided if more efficient back-up from medical or social services had been provided. • 78% said would consider involving SW before applying S136. • 56% satisfied with effectiveness of law involving the police in care of mentally ill. • 90% did not think the MHA was over-used.
Gray, R., Smedley, N. & Thomas, B. 1997	A review of 12 papers on S136, 3 of which referred to the 1959 Act. Implications for clinical practice, policy formulation and further research were discussed. London was the focus of population selection and comparison or differentiation was made between trends in the different	• Behaviour prior to S136 analysed differently in each paper – a pattern hard to detect. • There are no strict classification systems. • Unclear if information recorded by the police provides an accurate picture of a patient's behaviour prior to detention.

	Acts.	• Ethnic minorities are over-represented. • Single, unemployed males with a previous psychiatric history form the majority of those detained. • Schizophrenia is the most common diagnosis. • The majority of those referred under S136 will be admitted.

Table 5.1 (continued) Part X: Sections 135 & 136

Author and Year	Background	Main findings
Klijnsma, M.P., Bartlett, A.E. & Cohen, A. 1994	An audit of the differences in use of S136 between 13 District Health Authorities. 16 MHA administrators were interviewed by telephone to ascertain whether any agreements for S136 assessments existed and to measure the frequency of S136 use. Study based on opinion and anecdotal evidence but does support evidence found in other studies.	• 8 Districts had written policies, 4 did not. • The 13th District had one area with a policy and one without. • Place of safety was a psychiatric ward or hospital in 4 areas, a police station in 2, both of the above in 2, and in one case it was an A&E department. • In 4 of the areas without a policy, the Place of Safety was unclear. • S12 doctors carried out assessments in 5 policy and 2 non-policy areas. • Time period between referral and assessment was longer than 6 hours in most cases. • In 3 Districts assessments were carried out within 6 hours by both a doctor and a social worker. • 8 policy and 1 non-policy districts kept S136 records. • Reliable records indicated an annual range of 6-109 assessments! • Police brought patients to hospital unannounced/under S136 without right paperwork.
Latham, A. 1997	This study is in two parts and aimed to ascertain the procedures used in Section 136 as well as professional knowledge of the Act. 43 Chief Constables were interviewed regarding their force procedures involving Section 136. 410 active members of the APS were interviewed regarding their knowledge of the Act.	• 19/43 used a specific S136 form • Places of safety used were: police cells only, 60%; Police cells more commonly than hospitals, 22%; hospitals more commonly than police cells, 2%; hospitals only 16% • Only 20 police forces could provide annual figures of S136 assessments • S136 assessments are likely to be an underestimate • Only 15% of APS members and 7% of non-members were S12(2) approved • 30% of respondents were incorrect in their answers regarding treatment under S136 • 53% of APS members and 38% of non-members were aware of the correct duration of detention • 75% of members and 58% of non-members knew S136 could only be applied in a public place • 44% knew that both a registered medical practitioner and a SW were needed for assessment
Lowe-Ponsford, F. & Begg, A. 1996	The write-up in this study was unclear and some of the comments made by the authors did not correspond with the findings they presented. For example, they state that police surgeons rarely referred to a psychiatrist those who were not admitted - this is in stark contrast with the 38% admission rate. Any findings should be interpreted with	• 45.6% of adults were seen by a doctor, the remainder were not assessed as had not been detained formally (Of the latter, 53% were missing persons). • No-one was detained for the full 72 hours and only one for 48 hours. • Of those assessed, 38.8% were admitted. • Females were on average significantly older than the males (41yrs to 33yrs). • Females were less likely to be detained.

	caution owing to the nature of the sub-group studied (people detained at airports) and the small sample used.	• Of the 6 where diagnostic information was available, all were diagnosed as psychotic. • Police records lacking in information about whether person had been held under S136.

Table 5.1 (continued) Part X: Sections 135 & 136

Author and Year	Background	Main findings
Mokhtar, A.S. & Hogbin, P. 1993	Case note review of 68 patients on a locked ward. Study aimed to show clinical differences between patients admitted under S136 (n=39) or S2 or S4 (n=29). Most of the data showed little significant difference between the groups, which could have been caused by 'ward effect', i.e. studying a single specialist environment. Also, the less severe cases of S2/4 were not included and so the sample is a unique one in terms of diagnosis.	• Psychiatric hospital: 52.9% male; 47.1% female. • S136: 53.8% male; 46.2% female and S2/4: 51.7% male; 48.3% female. • 72% S136 and 79% of S2/4 were admitted out of working hours. • 12 (30.7%) were converted to a further section. • 9 of S2 group lapsed and remained in hospital; 2 S2 lapsed and were discharged; 3 S4 were converted to unknown; 6 S4 were allowed to lapse and remained in hospital. • 7 (17.9%) S136 made informal and discharged, 4 (10%) S136 lapsed and discharged and 15 (38.4%) S136 lapsed and stayed in hospital. • S136 were older than S2/4 by an average of 3 years. • 30.8% Section 136 and 41.4% of S2/4 were not British born. • 12.8% S136 were not Caucasian compared to 31% of S2/4. • 33% of S136 and 58.6% of S2/4 had a previous admission; 28% S136 had a previous conviction compared 13.8% of S2/4. • S2/4 stayed longer on average on both locked and hospital wards than did S136. • 74.4% of S136 and 62% of S2/4 were unemployed. • 38.5% of S136 and 41.4% of S2/4 had no follow-up support, both had more informal than professional support. • 76.9% of S136 and 72.4% of S2/4 were single. • 38.5% of S136 and 24% of S2/4 were of low-level education. • 69.2% of S136 and 82.7% of S2/4 had a psychotic condition.
Moore, M.R. & Moore, S. R. 1994	An audit of 2201 police cases over 3 yrs. Data presented on 66 of the 75 cases subject to S136. To promote use of PCs & a national d/b for police & police surgeons, but actual numbers too small & locality too limited to show significant trends. Some figs unclear.	• 43 males 65%; 23 females 35%. • 53% admitted to hospital. • 3% of all police cases were S136 assessments. • 42% unemployed.
Mosley, A. 1997	Literature Review and informal survey of social workers and police on the use of and attitudes toward S136. Qualitative paper based on opinions. Limited methodological information but provides some details reflected in other studies.	• Emphasises the impact of the Police and Criminal evidence Act (1984) on the implementation of S136. Eg – where the Police Station is the designated Place of Safety, a police surgeon must be called immediately unless an assessment under S136 by a registered medical practitioner can take place without delay.

Table 5.1 (continued) Part X: Sections 135 & 136

Author and Year	Background	Main findings
Pipe, R., Bhat, A., Matthews, B. & Hampstead, J. 1991	This was a concise paper containing plenty of demographic details on black and white differences from one psychiatric hospital's records of 99 S136 referrals over one year. A letter was also sent to 47 GPs. The study aimed to identify any strong differences in trends, social and clinical factors between black and white groups and to identify factors which render minorities more vulnerable.	• 52.5% male: 75% black; 36% white. 47.5% female: 25% black; 64% white. • Reasons for detention were 'threatening behaviour', 'incoherence', 'disturbed behaviour' and 'denial of illness'. • Blacks detained for 82%-54% of these reasons compared to 48%-21% in whites. • 85% of S136 admitted to hospital; majority were admitted as informal after 72 hrs. • 37.3% aged 20-29; 67.7% unemployed. • 40% stayed under one week. • 23% had no follow-up. • Of whole sample, 64.6% white and 21.2% afro/Caribbean, 5.1% African. • 58% of black and 25% of white had a previous S136 admission. • 57% black and 85% white had GP contact within 6 months. • 78% black and 50% white were single. • 91% blacks had fixed accommodation and 55% whites. • Over half the sample's last date of contact with GP was unknown. • 32% black and 9% white had previous diagnosis of schizophrenia & PD.
Rassaby, E. & Rogers, A. 1987	All police referrals over a 1 year period to either a psychiatric hospital or an Emergency Assessment Unit (EAU) in Greater London were examined as well as any people detained at a police station – as a place of safety. Study aimed to determine whether outcome of assessment was affected either immediately following referral or after extended periods of assessment. 326 subjects' case-notes reviewed. NB - Some of the data here is the same as that found in Rogers and Faulkner 1987. Also, there were no data available on whether follow-up care was used after EAU. Many of the police referrals to the EAU were the same individuals casting some doubt on the disposal methods used.	• Data is considered to be an underestimate of the actual numbers of police referrals as it only includes those clearly marked as such. • 7.6% EAU, 2.1% hospital & 10.7% police patients admitted under Part II of Act. • 29.7% EAU, 2.1% hospital & 28.6% of police patients were discharged from S136. • 0.7% of EAU and 91.4% hospital patients were admitted on a S136. • 20.3% and 36.8% of hospital patients admitted under another section. Police station referrals had no data on this. • 24.7% EAU, 3.6% of hospital and 39.3% of police S136 were admitted informally. • After further assessment, 45.6% of EAU and 21.4% of hospital S136 discharged. • 43.9% EAU and 75.7% hospital were admitted.
Revolving Doors Agency	This was a Home Office report examining the outcome of S136 arrests in 3 London Police stations. A retrospective case-note and police record review over 2 years examining 4 to 6 month periods of 218 mental health cases and 72 S136.	• Of 29 arrests, one was assessed by psychiatrist and an ASW; 2 by a forensic medical examiner and ASW; 8 by a forensic medical examiner and one was not assessed. • 20.6% of arrests were admitted to hospital.

		• Of the original 72, 69.4% were held at the police station and the rest at the hospital. • 75% of sample male; 67.4% of sample white, 32.6% non-white. • Significant variations were found between the 3 stations in terms of numbers of arrests – this thought to be explained by the different social profiles of the areas. • 2.3% of all arrests had a mental health problem. • 33% of these cases used S136. • 69% of S136 were initially taken to police station despite designated place of safety being the hospital. • Almost 40% were discharged from the police station without a proper assessment.

Table 5.1 (continued) Part X: Sections 135 & 136

Author and Year	Background	Main findings
Rogers, A. 1990	A presentation of unpublished PhD material with little information on methodolgy. An assessment of 160 police officers by structured interview and an examination of police records assessed their role; under what circumstances they invoke their powers and the nature of their professional relationship with psychiatrists	• Under 50% female. • 19% of S136 arrests were not made in public place. • 88% admitted to hospital. • Police were called to scene by 42% strangers/passers by; 15% neighbours, 13% relatives, 8% police and 7% health or social services. • 39% Afro/Caribbean in sample compared to 18% in estimated census data. • In only 5% of cases did police come across incidents in the street first hand. • 64% officers said they had no advanced warning that the matter involved anything other than criminal or public disorder matter. • Trouble & presence of vulnerable individuals meant police more likely to use powers. • Presence of relatives or neighbours had the opposite effect. • In 2/28 incidents police were unaware that S136 must be invoked in public place. • In 20% cases a psychiatric assessment was difficult to obtain. • Only 15% of officers rated psychiatrists attitudes toward them as positive • In only 3.5% cases did psychiatrist inform police of outcome of assessment. • High positive correlation between police and psychiatrists in terms of assessed danger to selves and others.
Rogers, A. & Faulkner A. 1987	First in the series of three projects carried out by MIND. 2 year retrospective study of police referrals using case notes and police records. Aimed to examine procedural variations in S136, and characteristics and past psychiatric history of the 273 people subject to S136 on 326 occasions. London, psychiatric hospital, police station, Emergency Assessment Unit (EAU). (see **Rassaby and Rogers 1987** – contains most of the data provided here but some discrepancies in data when compared to this study, possibly due to the time difference, eg. different reasons are provided for solutions and recommendations made)	Majority of referrals were male (more detailed data was not provided) • 15.5% assessed by police surgeon and 99.8% assessed by a GP • 60.8% were unemployed. • 17% of no fixed abode. • 79.5% of referrals had previous psychiatric treatment. A/C had significantly less than whites though. • 12.5% referred more than once during study period. • 31% had previous convictions but could be underestimate. • Drug induced illness and unspecified psychosis were more common in the A/C population. • 23% were mentally ill but not given diagnosis. • 36.2% of referrals were not accompanied by Form 434. • 17.2% not arrested in public places. • EAU doctors saw themselves as providing assessments, but at hospital appeared to be operating as admitting doctors. • SW only called upon if S2, 3 or 4 was necessary.

		• Hospital used 91.4% S136 for admissions; EAU & PS did not use S136 for this. • 70% of S136 in hospital were given medication.

Table 5.1 (continued) Part X: Sections 135 & 136

Author and Year	Background	Main findings
Rogers, A. & Rassaby, E. 1986a	Commentary on the role of SWs in London based on the data provided in **Rogers and Faulkner 1987**. Provides more detail on Social Work involvement, or lack of it, but from a commentary point of view.	• London (most frequent use of S136), SWs rarely involved in assessment of S136. • Outside the London area, where police station is used more often as place of safety, SWs appear to be more involved. • Found in borough that withdrawal of out of hours SW services resulted in increase from 4% to 72% of S136 in one year.
Rogers, A. & Rassaby, E. 1986b	Preliminary results of 1405 S136 cases. Final results can be found in **Rogers and Faulkner 1987**. Provides limited details of results but aim was to give a preliminary idea of the type of data collected.	• 92% admitted to hospital. • 90% waited full 72 hours before being assessed and a further 6% were then held under S5! • 82% unemployed. • 27% no fixed abode.
Shah, Y. & Markwick, C. 1989	Qualitative research containing limited detail about sample size and methodology. Designed to elicit the opinions of professionals by interview in relation to their understanding of and perceptions of others roles in the use of S136 as well as a reaction to the over-representation of black population. Carried out by Social Workers to amalgamate professionals' views.	• The introduction of form 434 by the Metropolitan police is not consistently used. • Police did not feel equipped to deal with mental illness. • Little/no SW involvement in assessment and provision of S136 – varied according to geographical location, place of safety used and different practices. • SWs felt they did not have the resources to meet the needs of the mentally ill nor did they recognise that they had a legal obligation to do so. • In one borough, decision to admit left to duty junior psychiatrist. • Police and psychiatrists disagreed over it being police role to wait in hospital with patient until they had been assessed. • Most psychiatrists did not think it essential to have a sound working knowledge of the law.

Table 5.1 (continued) Part X: Sections 135 & 136

Author and Year	Background	Main findings
Spence, S.A. & McPhillips, M.A. 1995	An examination of 65 S136 assessments in hospital. Prompted by the impression that personality disorder is over-represented in those detained under S136 in Westminster. Has prompted a prospective study but no details of the results of this yet.	• 67.7% male; 32.3% female. • 67.6% detained owing to bizarre behaviour; majority detained in a public place. • 27.6% cases the place of detention was unrecorded. • 32.3% were admitted under S2; 4.6% under S3. • 66% were admitted to hospital. • 83% were Caucasian, 15% Afro-Caribbean. • 81.5% had past psychiatric history. • Majority (37.2%) stayed for up to one week. • 87.6% were unemployed. • 81.5% unmarried. • Only 20% of referrals were from the catchment area. • 55.4% were followed up in another area or transferred as acute cases. • 20% had no follow-up. • 41.5% were registered with a GP. • Of the assessments made, 35.3% had diagnosis of schizophrenia. • Of those converted to a further Section 62.5% had a diagnosis of schizophrenia. • For PD, 36.9% of assessments made but only 8.3% of those converted.
Turner, T.H., Ness, M.N. & Imison, C.T. 1992	Aimed to obtain figures of people detained under S136 providing a clear psychiatric and social profile from case-notes and to analyse the effectiveness of care for such individuals. 2 year retrospective study of 163 referrals and a 3 month prospective study of 28 referrals to psychiatric hospital.	• 53% Afro/Caribbean male. • 49.7% detained during working hours. • Majority (36%) detained for causing a disturbance. • 87% were detained in a public place, • Information was unavailable in 7.9% of cases. • Ratio of hospital admissions were higher in the prospective study. • Information on time taken to assess available on only 25 cases. Majority of those were seen within 4 hours. • Black males were younger than their white counterparts. • 47.8% of S136 referrals were Afro-Caribbean. • 81% had a previous psychiatric admission. • 4% were in paid employment. • Significantly more repeat referrals went AWOL than first time referrals. • 29% had a prison record. • 62% of schizophrenia diagnoses were afro-Caribbean. • Males under 39yrs were over-represented.

Wallis, G. 1989	A psychiatrist's summary of a conference report performed by two speakers; a police Superintendent and the chairman of the MHAC. An opinion on the use of S136 is given and a small data set of 31 subjects is presented by police.	The following data was presented by the police Superintendent: • 29% admitted to hospital. • 72% of males were under 35 years.

Table 5.1 (continued) Part X: Sections 135 & 136

Author and Year	Background	Main findings
Weller, M.P.I., Weller, B.G.A., Baumann, S. And Coker, E. 1988	Retrospective study of case-notes over 11 year period including both 1959 and 1983 Act data. However, data is only reported for a 12 month prospective study of 44 police admissions was also carried out. Methodological quality and data are unclear. Study aimed to ascertain trends in the use of S136 as well as establishing whether the closure of a local large psychiatric institution would have an effect of the number of S136 referrals.	• Of the 44 police admissions, 47.7% had no documents and 45.4% were S136. • S136 was shown to decline significantly over study period. • The hospital studied has been criticised for high use of S136, although the authors report that the majority of these were of very disturbed patients.

Part 2: Chapter 6 - Miscellany

2.6.1 Introduction

This chapter describes some papers that are not easily placed elsewhere in the review. Nine specific issues were covered by these miscellaneous papers. This chapter deals with each separately, with the main research findings of the relevant studies summarised in the corresponding tables. Some studies cover more than one theme. The main themes that were identified were as follows:

- The use of electro-convulsive therapy (ECT) under the MHA
- The use of the Act in relation to violent episodes
- Aftercare
- The use of the Act in different settings: psychogeriatrics, forensic psychiatry, adolescent units and mental handicap
- The interdisciplinary use of the Act
- Training of staff in the use of the Act

2.6.2 Results

(i) The use of ECT under the MHA

ECT is a controversial treatment which can be given to patients against their will under Section 58 of the Act (treatment requiring consent or a second opinion). It may also be given in emergencies under Section 62 of the Act. The few papers that have specifically assessed the use of ECT under the Act are presented in Table 6.1. The best evidence comes from a study by Malcolm (1989) of 100 patients treated with ECT, where 27% of patients underwent ECT using the MHA. These were either treated under Section 62 (11%) or Section 58 of the Act (16%). Donelly (1992) in an audit of treatments for depression in an elderly ward found that 7 out of 11 patients given ECT had it against their will.

It is not known whether having ECT against the patient's will is associated with a poorer outcome, and such research would have to be balanced by the dangers of ignoring life threatening depression, which is the usual indication for the treatment. The only outcome we are aware of was identified in Malcolm's study which suggested that patients given the treatment against their will were more likely to find it frightening than those who consented to the treatment (67% vs 51%).

Table 6.1: ECT

Author and Year	Background	Main findings
Berrios, G.E. & Sage, G. 1986	All patients receiving ECT between 1983-1985 in a 30 bedded acute unit (n=76) were examined in relation to whether they broke their fast before receiving treatment (n=21). Fast-breaking was considered to be a form of passive refusal.	• Fast-breakers were more likely to be divorced, single or widowed, be detained under section, hold an unfavourable view of ECT and had not given consent for ECT.
Bhatnagar, K., Kennedy, P. & Morley, S. 1987	241 patients subject to ECT between 1980 and 1984 were examined. The decline in use of ECT was reported in conjunction with possible reasons for this. A structured interview of consultant psychiatrists was also carried out in order to assess their reasons for perceived changes.	• The proportion of first timers fell and the proportion treated as outpatients doubled over the time period studied. • No significant differences were found between the proportion of patients on compulsory orders, sex and age distribution, the time between referral and receiving ECT, or the diagnostic grouping.
Donnelly, P. 1992	Medical audit aimed to evaluate drug therapy in a cohort of depressed patients admitted to a functional ward for the elderly. 63 sets of case notes were used to assess the treatments given.	MHA was not main focus of the study. • In all but one of the S3 cases (no original figures provided) antidepressant medication was used prior to commencing ECT. • 7 out of 11 patients who received ECT did so under the MHA.
Malcolm, K. 1989	Patients' perceptions and knowledge of ECT were examined before and after treatment. Consecutive patients were interviewed until the total of 100 was reached over a one year period.	• 11 received emergency ECT under S62 of the Act. • 16 refused treatment and were given it compulsorily after 2nd opinion obtained. Of the patients who consented to treatment: • 65 were informal; 8 were detained under the Act. A total of 35 patients received ECT under the Act: • 8 had consented but their consent was not felt to be valid. • 5 initially consented but later withdrew their consent and were given ECT under the Act.

(ii) Violence and the MHA

It is unsurprising that violent behaviour is associated with the use of the MHA. The three studies that specifically addressed this issue are presented in table 6.2. Edwards et al (1988) found that violent incidents were more common in formal patients, but the majority of assaults occurring in their psychiatric unit were by informal patients. Powell et al (1994) assessed 1000 violent incidents in psychiatric units. They found that decisions related to sectioning patients were very rarely antecedents to violent acts. Forty-three percent of patients who had committed one violent act were detained under the MHA, as opposed to 91% of those who had committed ten or more violent acts. Agarwal and Roberts (1996) assessed the effect of transfer from a general adult psychiatry unit to one providing more care to forensic patients. Surprisingly, they found the rate of violent incidents fell when the number of mentally disordered offenders rose. However the study did not control for any confounders and the results are difficult to interpret or generalise.

Table 6.2: Violence and MHA

Author and Year	Background	Main findings
Agarwal, M. & Roberts, M. 1996	This study examined the pattern of violent behaviour in an interim secure unit over a two year period as a result of change in ward population. Some information is provided in relation to patients detained under either Part II or III of the Act. 135 case notes were reviewed.	• For year one, 67% were male; for year two 82% were male. Of the violent patients examined: • 1991: 76% were under civil section; 19% under criminal section. • 1992: 47% were under civil section; 41% under criminal section. • 1991: 52% were aged between 20-29 years. • 1992: 41% (majority) were aged 30-39 years.
Edwards, J.G., Jones, D., Reid, W.H. & Chu, C.C. 1988	All assaults occurring on a psychiatric unit in a general hospital were studied for one year (37 incidents involving 25 patients were recorded). The aim was to study the prevalence and severity of assaults and to investigate the characteristics of the assaultative group using a control group.	• Assaultative group: 72% informal; 28% detained under the Act. • Control group: 94% informal; 4% detained under the Act. • There were significantly more schizophrenic patients in the assaultive group.
Powell, G., Caan, W. & Crowe, M. 1994	Audit of all inpatients, day patients and outpatients in 3 hospitals within a south London health authority, collected over 13 months (1990-91). 275 patients involved in 1000 incidents of violent behaviour identified. The aim was to determine whether it is possible to identify events preceding incidents of violence.	• Decisions about the MHA or wards of court was an antecedent for less than 1% of incidents. • Individuals responsible for 10 or more incidents were more likely to have been detained under the Act (90.5%) than those who had committed only one assault (42.7%). • There was a significant preponderance of detained patients, most marked in female population: 91% of frequent assailants were detained compared to 29% of single assailants.

(iii) Aftercare in the MHA

Despite the emphasis of current policy and debate on aftercare of patients following admission to hospital, there is remarkably little written about the outcome of patients who have been detained and only two studies could be identified (table 6.3). Shaw and Holloway (1991) compared patients on forensic psychiatry, general psychiatry and general medical wards in terms of whether they had a GP. Psychiatric case-notes were less likely to contain the GP's name and address and psychiatric patients were less likely to be able to remember them. Sectioned patients were especially likely to not know their GP's details. Thus it appeared that those with the most complex needs had the poorest provision during their admission. Against this has to be balanced the fact that patients on forensic units have prolonged durations of stay, and it is to be hoped that discharge planning would involve identifying a GP.

Table 6.3: Aftercare

Author and Year	Background	Main findings
Jones, E., Alexander, J. & Howorth, P. 1996	This study investigated the provision and use of after-care services for a group of 77 patients suffering from schizophrenia, identified in acute psychiatric units in North Durham. Data were collected by review of case notes and interviews with patients, carers and key professionals; areas investigated included services received, level of disability, and users' and carers' satisfaction with the service.	• 31% were re-admitted under the MHA. • One person had seen a solicitor to appeal against their MHA section. • Compulsory admission was identified as one of the five measures used as an indicator of disability.
Shaw, J. & Holloway, J. 1991	190 inpatients case notes were examined and telephone interviews were carried out to compare how many forensic and general psychiatry and general medicine patients were registered with their GPs.	• Patients in the RSU were significantly less likely to have a GP. • 91.7% of forensic patients and 255 of general psychiatry patients who did not have a GP were detained under the Act.

(iv) Care of the elderly

Five studies have described the use of the MHA in elderly patients (table 6.4). Only one study reported the proportion of all admissions to psychogeriatric units under the MHA and estimated this to be approximately 5% (Feehan, 1994). Most of the studies have simply described the characteristics of elderly detained patients, without much further analysis. One exception is a paper by Srikumar and Orrell (1995) which assessed differences in the use of the MHA in elderly and younger patients. Their findings reflect much of what is known of the epidemiology and clinical features of mental disorder in the elderly. Thus a higher proportion of elderly sectioned patients were female; self-neglect was a common reason for sectioning in the elderly but not the young; and dementia – which was not diagnosed in the young group, was a common diagnosis in the older sectioned patients.

The other descriptive studies generally concur with these impressions. Self-neglect is an important reason for sectioning in this group, especially in those living alone. The use of sections for dementia are somewhat different to their use in functional psychosis: patients with dementia are more likely to be placed on briefer sections – for example, patients with dementia placed on a Section 5(2) are less likely to be converted onto a Section 2 or Section 3, and the use of Section 3 is more common in those with functional psychosis than dementia. Among patients living at home with carers, the commonest reason for admission was that the carer could no longer cope (Gilmore et al, 1994).

Only one study in the elderly assessed the outcome of detention (Morris and Anderson, 1994). This paper found that less than half of all elderly patients detained on the MHA return to their home, with many going into residential care and nearly 10% dying during their admission. The lack of comparative data with non-sectioned patients make these findings difficult to interpret. Differences were found between those with dementia and those with functional psychosis, with a much higher proportion of those with dementia being discharged into the care of nursing homes.

Table 6.4: Use of MHA in the Elderly

Author and Year	Background	Main findings
Donnelly, P. 1992	Medical audit aimed to evaluate drug therapy in a cohort of depressed patients admitted to a functional ward for the elderly. 63 sets of case notes were used to assess the treatment given to each patient	MHA was not main focus of the study. • In all but one of the S3 cases (no original figures provided) antidepressant medication was used prior to commencing ECT. • 7 out of 11 patients who received ECT did so under the MHA.
Feehan, C.J. 1994	A two year audit of a psychogeriatric hospital was undertaken using the section papers of all 35 patients detained to compare previously shown high use of S5(2) and to assess the use of the Act in detaining cognitively impaired patients against their wishes. Sections 2, 3, 5(2) and 58 are examined.	• 28.6% of sample male. • 5% (35) of all patients were detained. • 77.8% detained under S2; 22.2% detained under S3. • One patient was detained under S5(2) and was changed to S2. • No relatives appealed on the patients' behalves. • One patient appealed against S3 but withdrew appeal. • One patient appealed against S2 but failed. • Most common reason for detention was for treatment for self-neglect: underlying reasons for this were depression (11), dementia (12) and psychosis (8).

Table 6.4 (continued): use of MHA in the elderly

Author and Year	Background	Main findings
Gilmore, C., Wood, G.C. & Rigby, J.C. 1994	Aimed to determine which elderly patients were detained, why and with what result. A retrospective inspection of card index system detailing all detentions was carried out between 1983 and 1989 for all those over 65 years of age. 132 episodes of detention were identified. Sections 2, 3, 4 and 5(2) are included.	• 29.5% male. • 79.5% were admitted from home; 17.4% from hospital. Reasons for detention: • To protect others 4.5%; Hazardous behaviour 9.1%; Suicide risk 3%; Social disturbance 12.1%; Self-neglect 13.6%; Carer unable to cope 20.5%; For S58 treatment 3.8%; In the interests of health 27.3%; Unknown 5.3%. • Outcome of detention: Discharge upon section expiry 9.1%; Informal stay after section lapsed 71.2%; Discharged from section by RMO 9.1%; Converted to S3 4.5%; Discharged by tribunal or died 6.1%. • Mortality at one year post follow-up 27.3%. • Age range 64-93, mean 76.83 years. • Mean length of stay for detained patients was 12.0 weeks. • Mean length of stay post expiry of section was 8.3 weeks. Diagnoses: • 22.7% paraphrenic; 12.9% depression; 11.4% mania; 48.5% dementia; 3% delirium. Type of section used: • 86.4% detained under S2; 3% under S3; 7.6% under S5(2) - half of which were converted to S2. One conversion to S3 and remainder cancelled or lapsed. • Patients with dementia were significantly older than those with paraphrenia. • Paraphrenic group were significantly more likely to be living alone at time of detention. • Majority of non-converted S5(2) were demented. • Majority of converted S5(2) were paraphrenic. • Demented patients significantly less likely to be detained more than once. • Suicide risk and use of S58 were confined to depressed group as reasons for detention. • Hazardous behaviour, self-neglect and carer unable to cope were largely confined to dementia group. • Self-neglect was the most common reason for those living alone. • Carer unable to cope was the most common reason for those living with a carer. • Patients with paraphrenia most likely to be detained due to social disturbance.

		• Significantly fewer patients with dementia returned to their previous address post detention, relocation to a rest or nursing home was the commonest outcome. • Almost all of those going to Elderly Mentally Ill homes had dementia. • Half those detained had a final diagnosis of dementia compared to 38.5% of new referrals.

Table 6.4 (continued): use of MHA in the elderly

Author and Year	Background	Main findings
Morris, C. & Anderson, I.M. 1994	A retrospective survey of the use of the MHA in an old age psychiatric service. Consultants identified 32 patients placed under 36 sections over the past two years and their case notes were examined. The study is intended to be descriptive. Sections 2, 3 and 5(2) included.	• 25% male. Outcome of detention: • 39% sent home; 36% sent to residential care for the 1st time; 15% returned to residential care; 9% died. Age: Range 70-96 years. Mean 80 years. Living situation: • 82% at home: 62.9% of which alone; 37.1% with a carer. • 15% residential care. Diagnosis: • Paranoid psychosis 15.6%; Hypochondriacal disorder 3%; Depression 40.6%; Mania 6.3%; Dementia 37.5%. Sections used: • S2: 42.9%; S3: 51.4%; S5(2): 5.7%. • Demented patients were more frequently detained under S2 and the functionally ill under S3. • 55% were admitted because of worsening of mental state. • 15% were admitted because of physical decline due to mental disorder. • 91% of patients with dementia and 37% of patients with functional disorders were discharged to residential care. • More demented patients entered care for the first time than functionally ill patients. Outcome: • Median length of stay was 10 weeks. • Demented patients: 75% made moderate improvement, none made marked improvement. • Functionally ill patients: 24% made marked improvement 38% made moderate. • Of the 9 prescribed ECT under S3: 55% made moderate/marked improvement.

Table 6.4 (continued) use of MHA in the elderly

Author and Year	Background	Main findings
Srikumar, S. & Orrell, M.W. 1995	Survey based in a Southend catchment area. Characteristics of the elderly and younger adults admitted compulsorily under the Act were compared. A retrospective analysis of patients case notes during the period 1987 to 1993 revealed 163 admissions.	• Elderly: 36.6% male. • General Adult: 53.1% male. Detentions under the Act: • S2: elderly 67.1%; Adult 54.3%. • S4: elderly 22%; Adult 3.46%. • 63.4% of elderly and 69.6% of adults were detained out of office hours. Most common source of admission: • Elderly: CPN 26.9%; No services involved 47.4%. • Adults: Outpatient clinic 36.4%; No services involved 46.8%. Most common reasons for detention: • Elderly: Aggression/violence 48.8%; self-neglect 43.9%. • Adult: Aggression/violence 75.3%; suicide risk 16%. Source of referral: • Elderly: GP 87.8%; Police 6.1%. • Adult: GP 54.3%; Police 33.3%. Living alone: • Elderly 58%. • Adult 31.3%. Diagnosis: • Schizophrenia/paranoid state: Elderly 42.7%; adult 49.4%. • Depression: Elderly 18.3%; Adult 19.8%. • Mania: Elderly 14.4%; Adult 25.9%. • Dementia: Elderly 20.7%; Adult 0%.

(v) Forensic settings

Nearly all patients treated in forensic settings are detained under Parts II or III of the MHA. Thus most studies based in forensic settings cover more specific aspects of the use of the Act. Table 6.5 summarises the six studies identified in this area. Smith and Humphreys (1997) described the knowledge patients had of their voting rights and whether they had voted in the 1997 general election. 24 of 73 were judged eligible to vote, but the majority had not voted. Most did not know whether they were entitled to vote.

McLaren et al (1990) assessed the use of medication as required in a regional secure unit (RSU), where all 32 patients were detained under the MHA. Forty-seven percent of patients received PRN medication at some point during the 103 days of the study. In nearly one half of cases this was used to prevent or contain physical aggression. The study indicated that in most cases the use of PRN was associated with an improvement in the patient's mental state.

Four other papers describe aspects of the MHA in mentally impaired offenders on forensic units (Isweran and Bardsley, 1987; Mayor et al, 1990; Smith, 1988; Smith et al, 1990). These papers mainly aim to describe the workings of the units, and data on the MHA are incidental to their main findings.

Table 6.5: use of MHA in forensic settings

Author and Year	Background	Main findings
Isweran, M.S. & Bardsley, E.M. 1987	The reorganisation of a 56 bedded Interim Secure Unit prompted a study which aimed to determine the problems presented by mentally impaired patients with different needs. 39 patients were studied over an unknown time-period	• 23% detained under S3. • 26% under S37. • 37% under S37/41.
Mayor, J., Bhate, M., Firth, H., Graham, A., Knox, P. & Tyrer, S. 1990	Aim of study was to describe the services provided by this specialist unit for the treatment of offenders with mental handicap and for those requiring greater security than can be provided in a normal hospital setting. 42 people were admitted over the three year period studied.	Most patients are detained under the Act: • 40% were detained under S2 or S3 for some or all of their stay. • 24% admitted under S35, S37 or S38, one was subject to S41 restrictions. Source of admission: • Own or parent home 27%. • Other treatment wards 27%. • Courts 20%. • Local Authority accommodation 13%. • RSU 1 person. • Interim Secure Unit 11%. • Average length of stay was 5.7 months.

Table 6.5 (continued): use of MHA in forensic settings

Author and Year	Background	Main findings
McLaren, S.,Browne, F.W. & Taylor, P.J. 1990	Semi-structured interview and case note review used to collect data on 32 patients detained under Part II or III of the Act in a Regional Secure Unit. Patients were examined over a period of 103 days in order to describe the use of medication given PRN.	• 75% patients had schizophrenia (50% receiving PRN). • 15 patients (46.8%) received one or more doses of PRN. • 73% of doses were given under staff initiative; remainder patient requests. • 50% of PRN given at meal or medication times. Reasons for giving medication: • To relieve patient distress 32.7%. • To prevent physical aggression 24.7%. • To contain physical aggression 24%. • To contain verbal aggression 8.7%. • To relieve distress caused to others 0.6%. • Other 9.3%. Nursing interventions used prior to mediation: • 74% talking. • 34.7% distraction. • 28.7% going to room. • 18.7% ignoring behaviour. • 7.3% relaxation. Nursing interventions used post medication: • 64.7% talked to nursing staff; 5.3% talked to doctor; 47% talked to duty doctor. Changes in behaviour: • Agitated: 80.6% before - 46.8% after. • Verbally abusive: 60.6% before - 27% after. • Threatening violence: 54.6% before to 20.4% after. • Physically violent: 36.6% before – 7.8% after. • Sedated: 6.6% before - 20.6% after. • Other side effects: 2% before - 1.5% after • Majority (42.6%%) took 5-30 minutes to settle after medication.

Table 6.5 (continued): use of MHA in forensic settings

Author and Year	Background	Main findings
Smith, J. 1988	This study aimed to describe the characteristics of the patients admitted to an open forensic unit in order to assess the suitability of the facilities and the outcome of the treatment provided. All 50 mentally abnormal offenders already inpatients or admitted between 1984 and 1986 were included.	• 60% were detained under the Act. Of these 13 were on restriction orders. • 32% were on probation orders. • There was no correlation between legal status and diagnosis. • Detained patients resembled the general criminal population more closely than a psychiatric hospital population in terms of sex ratio. • Average age on referral was 31 years. •Those with a formal psychiatric diagnosis were as likely to be admitted on a probation order as under the MHA.
Smith, H. & Humphreys, M. 1997	A letter detailing the results of a questionnaire administered to 89 patients detained under the Act in a Regional Secure Unit The aim was to determine, the day after a general election, how many understood their right to vote, how many had wished to vote, and why they had not voted.	• 73 responded; 91.7% knew there had been an election but had not voted. • One patient had had a proxy vote but was told he could not use it. • Half would have liked to vote. • 68.6% did not know whether they were entitled to vote. • 20.9% had been told they could vote; this was incorrect in 71.4% of cases. • Of those who thought they could vote (no figures) 9 were correct. •In total 24 patients may have been eligible to vote.
Smith, J., Parker, J. & Donovan, M. 1990	Forty-six patients' case notes – admitted to a RSU between 1983-86 – were reviewed and were compared with 53 patients case notes admitted in 1989.	• Patients with personality disorder fell significantly from 52% to 25% • There was a non-significant increase in the proportion of patients suffering from schizophrenia and affective disorder • Recent admissions had fewer previous convictions (3.8 compared to 6.7), and there was a trend towards fewer public order ad sex offences • The average number of previous admissions to psychiatric hospitals fell from 4.1 to 2.0 • Behavioural aggression toward staff became less common, 46% to 23% •Fewer recent admissions had a history of absconding, 54% to 25%.

(vi) Mental impairment

Clarke et al (1992) aimed to identify all patients detained in the West Midlands under mental impairment or severe mental impairment categories. They found 55 subjects, and describe the proportion of cases on different sections, their diagnostic categories and their needs for secure accommodation. Most were in mental handicap hospitals, but a sizeable minority (27%) were in special hospitals. The majority (80%) were detained for criminal offences. A subgroup were also suffering from schizophrenia.

Kon and Bouras (1996) described the experiences of consultants and senior registrars in learning disabilities in a health region. A high proportion of patients with learning disabilities who were sectioned had additional psychiatric diagnoses. The study found that the majority of relatives and carers supported the section when it was applied.

Table 6.6: Use of the MHA for mental impairment

Author and Year	Background	Main findings
Clarke, D.J., Beasley, J., Corbett, J.A., Krishnan, V.H.R. & Cumella, S. 1992	A case note review and postal questionnaire aimed to identify all those who were detained with a classification of Mental Impairment (MI) and Severe Mental Impairment (SMI) (n=55) in the West Midlands. Demographic and clinical characteristics as well services being received and probable future needs are described in order to plan services which can best meet their needs.	• 85.5% of sample male. • 96.3% were detained under the Act.; 3.7% under the Criminal Procedures Insanity Act. • 72.7% identified as MI, 25.4% as SMI and 1 case as having mental illness but who fulfilled the criteria for mental impairment. • 67.2% resident in mental handicap hospitals; 27.3% in special hospitals ; 5.5% on leave and living in community. Of those in special hospitals: • 46.6% were on S3; 40% on S37/41. Of those in mental handicap hospitals: • 35% under S37; 27% under S37/41; 21.6% under S3. Of the 80% with criminal offences: • 38.6% were detained for violent offences; 29.5% for offences against property; 15.9% for sexual offences; and 15.9% for other offences. • 69% were aged 21-40, with average age being 33. • 60% had been in 'hospital' for more than 6 years continuously. • 75% diagnosed as mild mental retardation; 16% as moderate; and 9% as severe. • 25% of MI and 35.7% of SMI diagnosed as schizophrenic. • 25% of MI and 21.4% of SMI diagnosed as having organic disorder. • 27.5% of MI and 35.7% of SMI as having neurosis. Assessed need: • 10.9% require high security; 14.5% intensive supervision in locked facility; 38.2% close supervision and high staff ratio unlocked facility; 20% hostel or place in community; 16.3% assessments could not be made from the notes.

Table 6.6 (continued): Use of MHA for mental impairment

Author and Year	Background	Main findings
Kon, Y. & Bouras, N. 1996	Aimed to identify how the Act was being used in Learning Disabilities. A questionnaire was distributed to the 10 consultants and 3 senior registrars based in South Thames Region. Respondents completed the questionnaire on the last five cases they had sectioned. A total of 33 cases were identified between 1986 and 1993. S2, 3 and 37 are included	• 79% male. • Reasons for detention cited as 67% aggression; 6% sexual assault; 6% life-threatening weight problem; one case of challenging behaviour. • Average age of males was 31 and females 41 years. • 54% had previously been sectioned. • Mean length of section was 45 weeks. • 82% prescribed antipsychotic, antidepressant or mood stabilising medication; 60% were on antipsychotic medication; 21% were on depot neuroleptics; 34% were on carbamazepine or lithium Diagnoses: • 21% schizophrenia; 21% personality disorder; 15% bi-polar disorder; 15% autism Mental impairment: • 64% had mild learning disabilities; 21% moderate; 15% severe. • S2 12%; S3 in 46%; S7 (guardianship) in 21%. • Of S2 detentions all were classed as seriously mentally ill. • Of S3, 18% were serious mental illness; 9% personality disorder; 18% for other diagnoses. • Of S37, 21% accounted for all cases requiring court involvement. • 75% cases were admitted to various hospitals: acute psychiatric wards; long-stay mentally handicapped hospitals; medium secure regional unit; private hospital. • Average length of stay was 27 weeks. • Those sectioned under psychopathic disorder tended to stay twice as long as rest of population. • Mental and Severe Mental Impairment stayed 30 weeks; Mental illness 11 weeks. • 61% relatives and 88% carers supported section. • 21% relatives and 6% of carers were ambivalent about section.

(vii) Adolescent unit

Only one study has assessed the use of the Act in an adolescent unit (Nicholls et al 1996). The study described 33 patients detained over a ten year period in a single unit. 6.7% of all patients admitted to the unit had been formal at some point in their stay – indicating the use of the Act was less frequent in this adolescent units than in general adult psychiatric settings. The most common reason for detention was risk of harm to the patient.

Table 6.7: Use of the MHA in an adolescent unit

Author and Year	Background	Main findings
Nicholls, J.E., Fernandez, C.A. & Clark, A.F. 1996	A retrospective case note analysis was conducted over ten years to identify all admissions subject to detention under the Act (n=33) in an inpatient adolescent unit. The aim was to establish frequency of use and factors associated with its application in an adolescent inpatient unit serving 12-17 year olds. Sections 2, 3 and 5(2) included.	• 63.6% of cases male. • 6.7% of the total admissions were detained at some stage. • Of those 42.2% were admitted under section. Following information is based on those detained: • Mode age: 16 years 58%. • 42.4% diagnosed as suffering from mental illness: 8 bipolar disorder; 1 obsessive compulsive disorder; 2 anorexia; 1 anxiety state; 2 conduct disorder. 52 sections applied: • 40.4% S2; 32.7% S3; 26.9% S5(2). • 86% of S5(2) converted to S2 or S3. • 94% of S2 or S3 cases were recommended by the unit psychiatrist. • 47% of all cases were recommended by a GP. • Of those sections requiring SW assessment: 41.6% completed by unit SW; 5.5% by SW from children's team; 52.7% from an adult mental health team. • 3 appeals against S3 were made. All were upheld. • 6 appeals against S2 were made. 2 were released. • Act was used mostly in 16 year olds. Since 1991 ten 15 year olds and one 13 year old have been detained. • Reasons for detention were mainly for assessment and treatment in the interests of own health. • 8 cases mentioned violence or aggression towards others.

(viii) Interdisciplinary use of the MHA

One aspect of the MHA that has been studied in more depth is its interdisciplinary use. As the most commonly used sections (ie S2 and S3) require the agreement of social workers and two doctors – one of whom is usually the patient's GP, there are potential discrepancies in the way in which the Act is applied by the different professionals involved. Studies which have addressed this issue are presented in table 6.8.

This topic includes the only randomised controlled trial pertaining to the use of the MHA (Kendrick et al, 1995). The study randomised 373 GPs either to receive an intervention (education) or no intervention (control). The intervention involved the GPs being given education in the use of structured assessments of their long term mentally ill patients. One outcome studied was the rate of psychiatric admissions and admissions under the MHA over a two year period following the intervention. The study failed to show any effect of the intervention on total admissions or admissions under the MHA, however the statistical power – even in a large study such as this – may have been too low to detect a change in such relatively rare outcomes.

Conflict may arise when professionals have different views regarding the appropriateness of formal admission. Two studies have assessed such differences. Morgan et al (unpublished data) described a study which gave vignettes of clinical situations to approved social workers (ASWs), psychiatrists and GPs. The vignettes described a number of clinical presentations of probable mental illness. The trend was generally for psychiatrists to be most likely to recommend formal admissions and ASWs to be more cautious, with GPs falling somewhere between. In one vignette – where the use of the Act would have been inappropriate – more GPs than psychiatrists or ASWs would have sectioned the patient.

Sammut and Sergeant (1993) described actual cases where social workers had not supported psychiatrists' recommendations for patients to be detained. In most such cases the social workers felt the patient was not sufficiently ill to recommend detention. However, about one half of such patients were subsequently admitted to hospital, after a mean delay of four weeks. Compared to patients whom the social worker agreed to section, those who were not immediately sectioned were judged to have a worse outcome at three months.

Sheppard (1992a, 1992b) described 40 referrals for sectioning made by GPs to psychiatrists and compared them with 91 ordinary referrals. The findings are not surprising: those referred for sectioning were more likely to be clearcut cases of psychiatric disorder, and were considerably more likely to have psychotic illness. When compared with referrals for sectioning from other agencies (eg social workers, and police), GP referrals were less likely to lead to compulsory admissions.

Bhatti et al (1998/99) surveyed Section 12 Approved practitioners in the West Midlands. They found that knowledge of current mental legislation is limited even in basic areas such as definitions and procedure. This is of some concern given the role these practitioners play in making recommendations for compulsory detention.

Table 6.8: The Interdisciplinary Use of the MHA

Author and Year	Background	Main findings
Bhatti, V., Kenney-Herbert, J., Cope, R. & Humphreys, M. 1998/99	A one in five random sample of all S12 approved doctors, working in the West Midlands, was carried out. A purpose-designed interview schedule was used to determine the knowledge of mental health legislation among 83 practitioners	• None of the participants gave the correct definition of the term 'mental disorder' • 34% were able to specify the 4 legal categories of disorder used in the Act • 4% were able to correctly state the conditions excluded from the legal definition of mental disorder • 96% correctly identified the purpose of S2 and S3 but 71% did not know who could make the application • Fewer than half could name the grounds for S2 detention or how they differed from S3 • 61.5% did refer to the Act if in doubt • Over half used the CoP as their main source of knowledge; 41% said talking to colleagues fulfilled the same purpose • 2 practitioners never consulted any material
Kendrick, T., Burns, T.& Freeling, P. 1995	RCT of 373 GPs randomised into intervention and control. The aim was to assess the impact of teaching GPs to carry out structured assessments of their long-term mentally ill patients.	• No significant differences were found between the two groups in the two years after intervention in admissions under the Act or in admissions to psychiatric and day hospitals. • The small sample size gave this study limited power and clinically significant differences in these less common events may have been missed.
Morgan, J.F., Schlich, T. & Falkowski, W. 1998	20 ASW, 19 GP and 28 psychiatrists responded to an anonymous, confidential questionnaire containing 14 case vignettes. The study aimed to examine the differential application of the Act by these 3groups. Fisher's exact test used to analyse responses.	Differences were significant in 4 of the 14 case vignettes. Reasons for detention: • Anorexia nervosa cases: 35% ASW; 100% GP; 64% psychiatrist. • Deteriorating health: 35% ASW; 42% GP; 79% psychiatrist. • Danger to others: 75% ASW; 84% GP; 100% psychiatrist. • Deteriorating health: 0% ASW; 63% GP; 54% psychiatrist. • Act not applicable: 20% ASW; 84% GP; 18% psychiatrist.

Table 6.8 (continued): The Interdisciplinary Use of the MHA

Author and Year	Background	Main findings
Sammut, R.G. & Sergeant, H. 1993	A study of cases which were not supported by SWs in the medical recommendation for compulsory admission. Case notes were also examined to determine how soon after admission patients were administered medication. Cases were identified by psychiatrists when their recommendations had not been supported. Details were obtained from case notes and by interviewing patients, relatives, SWs, family doctors and psychiatrists. 33 cases are presented here alongside a comparison group ("controls") of patients who were initially detained.	• 60.6% recommended detentions were for S2; 33.3% for S3; 6% for S4. Reasons given by SWs for not supporting recommendation: • 64% patient not ill; 12% agreed to be admitted informally; 6% relatives opposed detention under S3; 3% (1 case) lacked insight; 3% did not need ECT; 3% with puerpal illness considered to be better off at home with child; 9% no reason given. During the 3 month follow-up: • 73% of cases received informal care. • 52% were detained after a mean delay of 28 days. Reasons for this detention: • 71% had a worsened schizophrenic state; 23% had worsened affective disorder; 6% had drug psychosis. • Of the 21 deemed to be insufficiently ill: 52% were detained within 3 months. • Of the 4 who agreed to informal care, 3 discharged themselves without doctor's agreement. One was still unwell at the 3 month follow-up. • The relative of the patient not judged to need ECT made a S3 application and the patient recovered after treatment. • The patient with puerpal illness did well out of hospital. • All 3 for whom no reason was given were later detained. • Significantly more cases than controls left hospital early. • 11 cases and 17 control received parenteral drugs. • 3 cases and 2 controls received ECT. • 3 cases received no medication at all. • The cases tended to be more ill than controls at 3 months.

Table 6.8 (continued): The Interdisciplinary Use of the MHA

Author and Year	Background	Main findings
Sheppard, M. 1992a	40 referrals for section assessment made by GPs were compared with 91 'other' referrals from GPs. The social and demographic characteristics, mental health state, social problems and the intervention undertaken were examined.	• Significantly more section referrals were women (80%). • Significantly more section referrals were previously known to psychiatric services. • 93% of section referrals and 80% of others were considered to be definite or borderline mentally ill. • Significantly more section referrals (83%) were 'definite' cases compared to 36% of 'other' referrals. • Significantly more section referrals (77% vs. 17%) were considered to be psychotic. • More section referrals suffered affective psychosis and schizophrenia. • Markedly fewer section referrals had practical or physical ill health problems. • Section referrals had significantly more social relation problems. Based on practitioner opinion there were significant differences between the mental health state of referrals: • 60% of section referrals vs. 11% of others were considered psychotic. • 15% of section referrals vs. 34% of others considered neurotic. • 18% of section referrals vs. 41% of others considered to have emotional or relationship problems.
Sheppard, M. 1992b	A second paper, using the same subject groups above. The aim was to examine the process and outcome of section assessment. GP section assessment referrals were compared with other section assessment referrals. Referrals who were compulsorily admitted were also compared with those not admitted compulsorily. Over one year, 40 referrals were made by GPs; 17 by the family; 13 by psychiatrists; 17 by other health professionals; 15 by the police; 9 by SWs; and 9 by others	• 35% of GP and 59% of other referrals received state benefits. • 46% GP and 29% other were cohabiting or married. • Significantly fewer GP referrals were compulsorily admitted. • 30% GP and 15% other were informally admitted. • 28% GP and 19% other not admitted at all. • 80% GP and 82% other referrals mental health problems were considered primary. • GP referrals averaged slightly more social problems. • Family relations and support were considered in all GP and 88% of other referrals. • 55.5% of psychotic cases were admitted compulsorily. • 88% of compulsory admissions were psychotic.

(ix) Training in the use of the MHA

We were only able to identify one paper (Harrison, 1996) which specifically addressed the training needs of practitioners involved in administering the MHA (see table 6.9). This study focussed on senior registrars in psychiatry who were asked how much training they had received, and how much they thought they needed. The results suggest that many of them felt under-trained in the use of the Act, with less than half reporting ever having received formal training in the use of the MHA.

Table 6.9: Training for practitioners in the use of the MHA

Author and Year	Background	Main findings
Harrison, J. 1996	This article describes a locally organised training day for senior registrars and reports on their previous experiences and future training needs in the use of the MHA. 31 trainees attended. Questionnaire given so SRs could describe any previous training in the MHA and suggest what form of training would be most useful to them. They were also asked to rate their current level of confidence in interpreting and using the Act on a scale of 1 to 10.	• 39% said they had previously received individual supervision in the use of the Act from a consultant. • 39% had attended audit meetings relating to the use of the Act. • 48% had received some formal training about the MHA. • 81% spontaneously suggested small group or workshop teaching with the opportunity to discuss real life situations. • 23% specifically requested multidisciplinary teaching, particularly with social workers.

2.6.3 General comments

There are a number of obvious gaps in current knowledge about the use of the MHA in these different contexts. Our knowledge of the Act as it is used in various clinical settings (such as mental impairment, forensic units and adolescent units) is based largely on small scale studies which do little more than describe practice in one particular unit. Most of these studies based in individual units were not specifically designed to examine the use of the MHA. It is therefore hard to know whether the findings of the studies described above can apply to wider settings.

There is greater knowledge of the use of the Act among elderly patients. The results of the research available suggesting that the different clinical picture of elderly patients with psychiatric disorder leads to a different use of the Act, with more emphasis on admitting patients for their health than for risk to others or risk of self harm. The importance of dementia as a diagnostic category in this group is demonstrated by these studies. However they give us little information to judge how well the Act is suited to these specific clinical problems.

The literature on the interdisciplinary use of the Act is important, indicating that social workers, GPs and psychiatrists have differing views as to how the Act should be used. The available information suggests that social workers are more cautious in their recommendations, but when they disagree with the decision of the psychiatrist the outcome is only to delay admission to hospital, with the net effect of delayed provision of effective treatment. We suspect that the changing climate in mental health care provision may have reduced these perceived differences between professional groups. Certainly more systematic studies of the outcome of MHA assessments where patients are not sectioned would be valuable for practitioners having to make these difficult decisions.

The lack of knowledge of the MHA amongst relevant professionals is of some concern. Both Bhatti (1998/9) and Harrison (1996) highlight the need for training and standards amongst doctors who are granted statutory powers.

References for Part 2 of the Report

Agarwal, M. and Roberts, M. Violence among psychiatric in-patients at an interim secure unit: Changes in pattern over a two-year period. MED-SCI-LAW. 1996; 36(1).

Akinkunmi, A. and Murray, K. Inadequacies in the Mental Health Act, 1983 in relation to mentally disordered remand prisoners. Med-Sci-Law. 1997; 37(1).

Anderson, J. B. and Parrott, J. Urgent psychiatric transfers from prison in England and Wales: A prison perspective.CRIM-BEHAV-MENT-HEALTH. 1995; 5(1).

Andoh, B. The job that nobody wants. Police Review. 1994; 4 March.

Ashmore, R. Factors influencing psychiatric nurses' use of section 5(4). Nurs-Times. 1992 a; 8844-7.

Ashmore, R. Qualifying Nurse's knowledge of section 5(4). Nursing Times. 1992 b; 8846.

Ashmore, R . The use of Section 5(4) to detain patients. Nursing Times. 1991; 8758.

Banerjee, S., Bingley, W., Murphy, E. Deaths of detained patients. A review of reports to the Mental Health Act Commission. Mental Health Foundation 1995

Barnes, M. Assessing for compulsory detention: applying the social perspective? Research, Policy and Planning. 1990; 814-19.

Bartlett, A. Rhetoric and reality: What do we know about the English special hospitals? Special Issue: Forensic treatment. INT-J-LAW-PSYCHIATRY. 1993; 16(1-2).

Bean, P.; Bingley, W.; Bynoe, I.; Faulkner, A.; Rassaby, E., and Rogers, A. Out of harm's way: MIND's research into police and psychiatric action under section 136 of the Mental Health Act1991.

Bebbington, P. E.; Feeney, S. T.; Flannigan, C. B.; Glover, G. R.; Lewis, S. W., and Wing, J. K. Inner London collaborative audit of admissions in two health districts II: Ethnicity and the use of the mental health act. BR-J-PSYCHIATRY. 1994; 165(DEC.).

Berrios, G.E. & Sage, G. Patients who break their fast before ECT. BR-J-PSYCHIATRY. 1986; 149. 294-295

Berry, R. The Police Journal. The Police Journal. 1996.

Bhatnagar, K.; Kennedy, P., and Morley, S. Decline in the use of ECT: The York Study. Bulletin of the Royal College of Psychiatrists. 1987; 11.

Bhatti, V., Kenney-Herbert, J., Cope, R. & Humphreys, M. Knowledge of current mental health legislation among medical practitioners approved under Section 12(2) of the Mental Health Act 1983 in the West Midlands

Bindman, J. and Reid, Y. Patients' Perceptions of coercion during hospital treatment and community follow-up; summary of preliminary data April 1998. Unpublished Data. 1998.

Birmingham, L.; Mason, D., and Gambin, D. Prevalence of mental disorder in remand prisoners: consecutive case study. BR-MED-J. 1996; 313.

Bowl, R.; Barnes, M., and Fisher, M. A real alternative. Community Care. 1987; 66726-28.

Bowler, C. and Cooper, S. A. Section 5(4). PSYCHIATR-BULL. 1993; 17147-149.

Bradley, C.; Marshall, M., and Gath, D. Why do so few patients appeal against detention under section 2 of the mental health act? BR-MED-J. 1995; 310364-367.

Brooke, D.; Taylor, C.; Gunn, G., and Maden, A. Point prevalence of mental disorder in convicted male prisoners in England and Wales. BR-MED-J. 1996; 313.

Brown, N. S. Section 5(2) Audit. PSYCHIATR BULL. 1991; 15706-707.

Buller, C.; Storer, D., and Bennett, R. A survey of general hospital in-patients detained under Section 5(2) of the 1983 Mental Health Act. PSYCHIATR-BULL. 1996; 20733-735.

Burns, T. and Raphael, F. Why do so few patients appeal against detention under section 2 of the Mental Health Act? Low appeal rate may reflect trust in doctors' judgement [letter; comment]. BR-MED-J. 1995; 3101196.

Cherrett, K. Policing the mentally ill: An attitudinal study of police contact with mentally disordered persons within the Gwent Constabulary . The Police Journal. 1995.

Clarke, D. J.; Beasley, J.; Corbett, J. A.; Krishnan, V. H. R., and Cumella, S. Mental impairment in the West Midlands. MED-SCI-LAW. 1992; 32(3).

Cooper, S. A. and Harper, R. Section 5(2): who acts as the consultant's nominated deputy? PSYCHIATR BULL. 1992; 16759-761.

Cope, R. The compulsory detention of Afro-Caribbeans under the Mental Health Act. New Community. 1989; 15343-356.

Cutajar, P. and Hampson, M. Time to amend section 135. PSYCHIATR-BULL. 1997; 21.

Davies, S.; Thornicroft, G.; Leese, M.; Higgingbotham, A., and Phelan, M. Ethnic differences in risk of compulsory psychiatric admission among representative cases of psychosis in London. Br-Med-J. 1996; 312(7030).

Dimond, B. The right of the nurse to detain informal patients in psychiatric hospitals in England and Wales. Med-Law. 1989; 8535-47.

Donnelly, P. Medical audit in an elderly depressed cohort. IR-J-PSYCHOL-MED. 1992; 9(1).

Dunn, J. and Fahy, T. A. Police admissions to a psychiatric hospital. Demographic and clinical differences between ethnic groups. BR-J-PSYCHIATRY. 1990; 156(MAR.).

Durani, S. K. and Ford, R. Pattern of hospital admissions before and following the Mental Health Act 1983. PSYCHIATR BULL. 1989; 13182-183.

Dutta, A. and Fleet, T. W. Audit in two acute psychiatric units. PSYCHIATR-BULL. 1991; 15351-352.

Edwards, J. G.; Jones, D.; Reid, W. H., and Chu, C. C. Physical assaults in a psychiatric unit of a general hospital. American Journal of Psychiatry. 1988; 145(12).

Ellis, D. and Lewis, S. Psychiatric presentations to an A&E department. PSYCHIATR-BULL. 1997; 21.

Exworthy, T.; Parrott, J. M., and Bridges, P. K. Section 48 an underused provision? PSYCHIATR-BULL. 1992; 16(2).

Fahy, T. A. The police as a referral agency for psychiatric emergencies - a review. MED SCI LAW. 1989; 29(4).

Fahy, T. A.; Bermingham, D., and Dunn, J. Police admissions to psychiatric hospitals: a challenge to community psychiatry. MED-SCI-LAW. 1987; 27.

Fahy, T. A. and Dunn, J. Where Section 136 fails. Police Review. 1987.

Feehan, C. J. Audit of the use of the Mental Health Act in a psychogeriatric hospital. INT-J-GERIATR-PSYCHIATRY. 1994; 9(7).

Fennell, P. Double Detention under the Mental Health Act 1983 - A case of extra-parliamentary legislation? The Journal of Social Welfare and Family Law. 1991; 3.

Gilmore, C.; Wood, G. C., and Rigby, J. C. Elderly patients and the Mental Health Act 1983. INT-J-GERIATR-PSYCHIATRY. 1994; 9(10).

Gray, R.; Smedley, N., and Thomas, B. The use of Section 136: A review of research 1972 - 96. Psychiatric Care. 1997; 4(2).

Grounds, A. The use of the remand provisions in the 1983 Mental Health Act. The Bulletin of the Royal College of Psychiatrists. 1988; 12(4).

Gunn, J.; Maden, A., and Swinton, M. Treatment needs of prisoners with psychiatric disorder. BR-MED-J. 1991; 303.

Hajioff, J. Managing mentally abnormal offenders. PSYCHIATR BULL. 1989; 13480-481.

Hall, A. D.; Puri, B. K.; Stewart, T., and Grahame, P. S. Doctors' holding power in practice: Section 5 (2) of the Mental Health Act 1983. MED-SCI-LAW. 1995; 35(3):231-236.

Hargreaves, D. The transfer of severely mentally ill prisoners from HMP Wakefield: A descriptive study. J-FORENSIC-PSYCHIATRY. 1997; 8(1):62-73.

Harrison, J. Training in the mental health act: See one, do one, teach one? PSYCHIATR-BULL. 1996; 20(3):160-161.

Harrison, S. Nurses are reluctant to use s.5(4) of the Mental Health Act 1983 and need better risk assessment skills. Dissertation. 1997.

Hatfield, B.; Huxley, P., and Mohamad, H. Social factors and compulsory detention of psychiatric patients in the U.K. The role of the approved social worker in the 1983 Mental Health Act. Int-J-Law-Psychiatry. 1997 Summer; 20(3):389-97.

Hatfield, B. and Mohamad, H. Women, Men and the MHA (1983). Research, Policy and Planning. 1994; 12(3):6-10.

Hatfield, B.; Mohamad, H., and Huxley, P. The 1983 Mental Health Act in five local authorities: a study of the practice of approved social workers. Int-J-Soc-Psychiatry. 1992; 38(3):189-207.

Hatfield, B. & Robinshaw, P. The use of compulsory powers by approved social workers in five local authorities. Some trends over two years. Journal of Mental Health. 1994, Vol. 3, 339-350

Hoare, S. and O'Brien, G. The impact of the Mental Health (Ammendment) Act 1983 on admissions to an interim Regional Secure Unit for mentally handicapped offenders. PSYCHIATR-BULL. 1991; 15(9):548-550.

Huckle, P. L. A survey of sentenced prisoners transferred to hospital for urgent psychiatric treatment over a three-year period in one region. Med-Sci-Law. 1997; 37(1):37-40.

Huws, R.; Longson, D.; Reiss, D., and Larkin, E. Prison transfers to special hospitals since the introduction of the Mental Health Act 1983. J-FORENSIC-PSYCHIATRY. 1997; 8(1):74-84.

Huxley, P. and Kerfoot, M. Variation in requests to social services departments for assessment for compulsory psychiatric admission. SOC-PSYCHIATRY-PSYCHIATR-EPIDEMIOL. 1993; 28(2):71-76.

Isweran, M. S. and Bardsley, E. M. Secure facilities for mentally impaired patients. The Bulletin of the Royal College of Psychiatrists. 1987; 11(2):52-54.

James, D. V. and Hamilton, L. W. The Clerkenwell scheme: Assessing efficacy and cost of a psychiatric liaison service to a magistrates' court. BR-MED-J. 1991; 303(6797).

Johnson, S.; Leese, M.; Brooks, L.; Clarkson, P.; Guite, H.; Thornicroft, G.; Holloway, F., and Wykes, T. Frequency and predictors of adverse events: The PRiSM psychosis study (3). Br-J-Psychiatry (1998).

Johnson, S.; Ramsay, R.; Thornicroft, G.; Brooks, L.; Lelliot, P.; Peck, E.; Smith, H.; Chisholm, D.; Audini, B.; Knapp, M., and Goldberg, D. London's Mental Health: The report to the King's Fund London Commission1997.

Johnson, S.; Wright, S.; Bindman, J.; Szmukler, G. I.; Bebbington, P.; Kuipers, E., and Thornicroft, G. Mental Health Service Delivery and Coercion: Patient attitudes to compulsory treatment & assertive community follow up. Conference Presentation. Maudsley Continuing Care Study.

Jones, E.; Alexander, J., and Howorth, P. Out of hospital: after-care for people with schizophrenia. Health Trends. 1996; 28(4):128-31.

Joseph, P. L. and Potter, M. Mentally disordered homeless offenders - diversion from custody. Health Trends. 1990; 22(2).

Joyce, J.; Morris, M., and Palia, S. S. Section 5 (2) audit. PSYCHIATR-BULL. 1991; 15224.

Kaul, A. Interim hospital order--a regional secure unit experience. Med-Sci-Law. 1994; 34(3).

Kendrick, T.; Burns, T., and Freeling, P. Randomised controlled trial of teaching general practitioners to carry out structured assessments of their long term mentally ill patients. BR-MED-J. 1995; 311(6997).

Klijnsma, M. P.; Bartlett, A. E., and Cohen, A. Section 136 agreements in a regional health authority. PSYCHIATR BULL. 1994; 18.

Kon, Y. and Bouras, N. The use of the Mental Health Act in learning disabilities. PSYCHIATR-BULL. 1996; 20(10).

Kwame, M. Something borrowed from the blues. Editorial. British Medical Journal. 1999; 316. 616-617.

Langley, G. Why do so few patients appeal against detention under section 2 of the Mental Health Act? Managers should review patients who do not appeal [letter; comment]. BR-MED-J. 1995; 3101196; discussion 1197.

Latham, A. The Cinderella Section: room for improvement in the documentation and implementation of S136 of the MHA 1983. Journal of Clinical Forensic Medicine. 1997, 4, 173-175

Leavey, G.; King, M.; Cole, E.; Hoar, A., and Johnson Sabine, E. First-onset psychotic illness: patients' and relatives' satisfaction with services. Br-J-Psychiatry. 1997; 170.

Li, D. Section 5(2) - following the rules? PSYCHIATR-BULL. 1993; 17242-243.

Lock, M. Inadequacies in the Mental Health Act 1983 in relation to mentally disordered remand prisoners [letter]. Med-Sci-Law. 1997; 37(2).

Lowe-Ponsford, F. and Begg, Ayaz. Place of Safety and Section 136 at Gatwick Airport. Med Sci Law. 1996; 36(4).

Malcolm, K. Patients' perceptions and knowledge of electroconvulsive therapy. PSYCHIATR BULL. 1989, 13, 161-165

Marshall, M.; Bradley, C., and Gath, D. Why do so few patients appeal against detention under section 2 of the Mental Health Act? Authors' reply. [letter; comment]. BMJ. 1995; 3101197.

Mason, P. and Turner, R. Audit of the use of doctors' holding power under Section 5 (2) of the Mental Health Act 1983. Health Trends. 1994; 2644-46.

Mayor, J.; Bhate, M.; Firth, H.; Graham, A.; Knox, P., and Tyrer, S. Facilities for mentally impaired patients: three years experience of a semi-secure unit. PSYCHIATR-BULL. 1990; 14(6).

McKenzie, K.; van Os, J.; Fahy, T. A.; Jones, P.; Harvey, I; Toone, B., and Murray, R. Psychosis with good prognosis in Afro-Carribean people now living in the United Kingdom. BR-MED-J. 1995; 311.

McLaren, S.; Browne, F. W., and Taylor, P. J. A study of psychotropic medication given 'as required' in a regional secure unit. Br-J-Psychiatry. 1990; 156.

Mokhtar, A.S. & Hogbin, P. Police may underuse Section 136. Med-Sci-Law. 1993; 33 (3); 188-196

Moodley, P. and Thornicroft, G. Ethnic group and compulsory detention. MED-SCI-LAW. 1988; 28(4).

Moore, M. R. and Moore, S. R. The potential for the use of personal computers in clinical forensic medicine. J-CLIN-FORENSIC-MED. 1994; 1(3).

Morgan, J. F.; Schlich, T., and Falkowski, W. Application of the powers of compulsory admission to psychiatric hospital by General Practitioners, Social Workers and Psychiatrists. Med Sci Law (in Press). 1998.

Morris, C. and Anderson, I. M. The use of the Mental Health Act in elderly patients in one health district. PSYCHIATR-BULL. 1994; 18(8).

Mortimer, A. M. Changes in the use of the Mental Health Act 1983 four years from its inception in Leeds Eastern Health Authority. MED-SCI-LAW. 1990; 30309-312.

Mosley, A. Room for improvement. Section 136 of the Mental Health Act 1983. Issues of implementation in multi-disciplinary practice. Http://Www.Imhl.Com/Project1.Htm. 1997.

Naik, P. C. and Klenka, L. Why do so few patients appeal against detention under section 2 of the Mental Health Act? Rate of appeal may be higher elsewhere [letter; comment]. BR-MED-J. 1995; 3101195-6; discussion 1197.

Naismith, L. J. and Coldwell, J. B. A comparison of male admissions to a special hospital 1970-71 and 1987-88. MED-SCI-LAW. 1990; 30(4).

Nasser, M.; Hunt, A., and Walker, T. Mental Health Act Monitoring Group. A five year audit experience . Network. 1993; 111-3.

Nemitz, T. & Bean, P. Discrepancies and inaccuracies in statistics for detained patients. PSYCHIATR-BULL. 1995; 19(1): 28-32

Nicholls, J. E.; Fernandez, C. A., and Clark, A. F. Use of mental health legislation in a regional adolescent unit. PSYCHIATR-BULL. 1996; 20(12).

O'Dwyer, J. M. and Mann, B. S. Psychiatric intensive care after two years. PSYCHIATR BULL. 1989; 13421-422.

O'Dwyer, J. and Neville, P. Appeals against Section 2 of the Mental Health Act 1983. PSYCHIATR BULL. 1991; 15225-226.

O'Dwyer, J. and Whitton, I. Why do so few patients appeal against detention under section 2 of the Mental Health Act? Intellectually elite are more likely to appeal [letter; comment]. BR-MED-J. 1995; 3101196.

O'Grady, J. The complementary roles of regional and local secure provision for psychiatric patients. Health Trends. 1990; 22(1).

O'Grady, J.; Courtney, P., and Cunnane, J. The provision of secure psychiatric services in Leeds; paper i. a point prevalence study. Health Trends. 1992; 24(2).

Parkman, S., Davies, S., Leese, M., Phelan, M. & Thornicroft, G. Ethnic differences in satisfaction with mental health services among representative people with psychosis in South London: PriSM study 4. 1997. British Journal of Psychiatry. 171

Patrick, M.; Higgit, A.; Holloway, F., and Silverman, M. Changes in an inner city psychiatric inpatient service following bed losses: a follow-up of the East Lambeth 1986 Survey. Health Trends. 1989; 21(4).

Pierzchniack P.; Purchase, N., and Kennedy, H. Liaison between prison, court and psychiatric services. Health Trends. 1997; 29(1).

Pipe, R.; Bhat, A.; Matthews, B., and Hampstead, J. Section 136 and African/Afro-Caribbean minorities. Int-J-Soc-Psychiatry. 1991; 37(1).

Pourgourides, C.; Prasher, V. P., and Oyebode, F. Use of Section 5(2) in clinical practice. PSYCHIATR-BULL. 1992; 1614-16.

Powell, G.; Caan, W., and Crowe, M. What events precede violent incidents in psychiatric hospitals? Br-J-Psychiatry. 1994; 165(1).

Puri, B. K. and Bermingham, D. F. High rate of Section 4 admissions: clinical implications and possible explanation. PSYCHIATR-BULL. 1990; 1421-22.

Puri, B. K.; Rose, G., and Bermingham, D. Emergency admissions under Section 4 of the Mental Health Act 1983: reasons for a high rate. Health Trends. 1992; 2485-88.

Rassaby, E. and Rogers, A. Psychiatric referrals from the police: variations in disposal at different places of safety. The Bulletin of the Royal College of Psychiatrists. 1987; 11(3).

Revolving Doors Agency. The use of section 136 Mental Health Act in three inner London police divisions, Report to the Home Office.

Robertson, G. The restricted hospital order. PSYCHIATR BULL. 1989; 13(1).

Robertson, G.; Dell, S.; James, K., and Grounds, A. Psychotic men remanded in custody to Brixton Prison. Br-J-Psychiatry. 1994; 164(1).

Rogers, A. Policing mental disorder: controversies, myths and realities. Social Policy and Administration. 1990; 24(3).

Rogers, A. and Faulkner, A. A Place of Safety. MIND's research into police referrals to the psychiatric services. 1987.

Rogers, A. and Rassaby, E. Mental Health Act 1983 (section 136). Have you opted out? Community Care. 1986a ; 30.

Rogers, A. and Rassaby, E. Picked up and put away. Openmind. 1986b ; 20(4).

Romilly, C., Parrott, J. & Carney, P. Limited duration restriction orders: what are they for? Journal of Forensic Psychiatry, 1997. 8, 562-572

Rusius, C. W. The Mental Health Act - what does the patient think? PSYCHIATR-BULL. 1992; 16(5).

Sackett, K. Discharges from section 3 of the Mental Health Act 1983; changes in practice. Health Trends. 1996; 2864-67.

Sainsbury Centre for Mental Health. A one-day visit to 309 acute psychiatric wards by the Mental Health Act Commission in collaboration with the Sainsbury Centre for Mental Health1997.

Salib, E. and Iparragirre, B. Detention of in-patients under section 5(2) of the Mental Health Act 1983. Med-Sci-Law. 1998; 3810-6.

Sammut, R. G. and Sergeant, H. Disagreements between psychiatrists and social workers over comulsory admissions under the 1983 Mental Health Act. PSYCHIATR-BULL. 1993; 17(8).

Sensky, T.; Hughes, T., and Hirsch, S. Compulsory psychiatric treatment in the community. I. A controlled study of compulsory community treatment with extended leave under the Mental Health Act: special characteristics of patients treated and impact of treatment. Br-J-Psychiatry. 1991a; 158792-9, 804.

Sensky, T.; Hughes, T., and Hirsch, S. Compulsory psychiatric treatment in the community II. A controlled study of patients whom psychiatrists would recommend for compulsory treatment in the community. Br-J-Psychiatry. 1991b; 158799-804.

Shah, Y. and Markwick, C. From the margin to the centre: an examination of Section 136 of the Mental Health Act 19831989.

Shaw, J. and Holloway, J. Who is your general practitioner? BR-MED-J. 1991; 303(6803).

Sheppard, M. Referral source and process of assessment: A comparative analysis of assessments for compulsory admission under the Mental Health Act ,1983. Practice. 1991; 5284-298.

Sheppard, M. General Practitioners' referrals for compulsory admission under the Mental Health Act. I: Comparison with other GP mental health referrals. PSYCHIATR-BULL. 1992a; 16(3). 138-139

Sheppard, M. General Practitioners' referrals for compulsory admission under the Mental Health Act. II: The process of assessment. PSYCHIATR-BULL. 1992b; 16(3). 139-141

Singh, S.P., Croudace, T., Beck, A. & Harrison, G. Perceived ethnicity and the risk of compulsory admission. Social Psychiatry and Psychiatric Epidemiology. 1998. 33, 39-44

Smith, H. and Humphreys, M. Changes in laws are necessary to allow patients detained under Mental Health Act to vote [letter]. BMJ. 1997; 315(7105).

Smith, J. An open forensic unit for the borderline mentally impaired offender. The Bulletin of the Royal College of Psychiatrists. 1988; 12(1).

Smith, J., Parker, J. & Donovan, M. Is the role of secure units changing? PSYCHIATR-BULL. 1990, 14(12), 713-714

Soothill, Keith; Kupituksa, Pisamai; Badiani, Dinesh, and Macmillan, Fiona. Compulsory admissions to mental hospitals: A replication study. INT-J-LAW-PSYCHIATRY. 1990; 13(3).

Spence, S. A. and McPhillips, M. A. Personality disorder and police section 136 in Westminster: A retrospective analysis of 65 assessments over six months. MED-SCI-LAW. 1995; 35(1).

Srikumar, Siva and Orrell, Martin W. Age and compulsory admission. INT-J-GERIATR-PSYCHIATRY. 1995; 10(7).

Thomas, C. S.; Stone, K.; Osborn, M.; Thomas, P. F., and Fisher, M. Psychiatric morbidity and compulsory admission among UK-born Europeans, Afro-Caribbeans and Asians in central Manchester [see comments]. Br-J-Psychiatry. 1993; 163.

Turner, T. H.; Ness, M. N., and Imison, C. T. 'Mentally disordered persons found in public places'. Diagnostic and social aspects of police referrals (Section 136). PSYCHOL-MED. 1992; 22(3).

Turner, T. H. Why do so few patients appeal against detention under section 2 of the Mental Health Act? New Zealand's system has much to offer [letter; comment]. BR-MED-J. 1995; 3101196-7.

Van Os, J.; Fahy, T. A.; Jones, P.; Harvey, I.; Sham, P.; Lewis, S.; Bebbington, P.; Toone, B.; Williams, M., and Murray, R. Psychopathological syndromes in the functional psychoses: Associations with course and outcome. PSYCHOL-MED. 1996; 26(1).

Wallis, G. Royal Society of Health - Implementing sections 135 and 136 of the Mental Health Act. Conference Report. PSYCHIATR BULL. 1989; 13.

Ward, J. How useful is Section 5(4)? Nursing Times. 1991; 8762-63.

Webster, L.; Dean, C., and Kessel, N. Effect of the 1983 Mental Health Act on the management of psychiatric patients. Br-Med-J-Clin-Res-Ed. 1987; 2951529-32.

Weller, M. P. I.; Weller, B. G. A.; Baumann, S., and Coker, E. The local use of Section 136. The Bulletin of the Royal College of Psychiatrists. 1988; 12(6).

Winterson, M. J. and Barraclough, B. M. Effect of 1983 Mental Health Legislation on compulsory admissions to a district general hospital. The Lancet. 1984; ii44.

Winterson, M. J. and Barraclough, B. M. Effects of 1983 Mental Health Act [letter]. Lancet. 1985; 21426.

Appendix A: Journals identified in electronic databases

(By journal index name - numbers of references in parentheses)

- Acta Psychiatr Scand (3)
- Acta-Psychiatr-Scand-Suppl (2)
- ADM-POLICY-MENT-HEALTH (2)
- Administration-in-Mental-Health (1)
- Advances-in-Nursing-Science (1)
- AIDS-CARE (1)
- American-Journal-of-Orthopsychiatry (1)
- American Journal of Psychiatry (9)
- American-Psychologist (5)
- Archives of General Psychiatry (2)
- ASIAN-MED-J (1)
- Aust-N-Z-J-Psychiatry (10)
- BMJ (4)
- Br-J-Hosp-Med (2)
- BR-J-NEUROSURG (1)
- Br-J-Nurs (3)
- Br-J-Psychiatry (35)
- Br-J-Psychiatry-Suppl (1)
- BR-MED-J (32)
- Br-Med-J-Clin-Res-Ed (11)
- British-Journal-of-Criminology (1)

- British-Journal-of-Occupational-Therapy (1)
- British-Journal-of-Social-Work (2)
- BULL-AM-ACAD-PSYCHIATR-LAW (2)
- Bulletin of Medical Ethics (1)
- Bulletin-of-the-British-Psychological-Society (3)
- CAN-J-COMMUNITY-MENT-HEALTH (1)
- CAN-J-PSYCHIATR (23)
- Can-Med-Assoc-J (6)
- Clinical-Psychologist (1)
- Community-Ment-Health-J (2)
- Community-Mental-Health-in-New-Zealand (3)
- COMPR-PSYCHIATRY (1)
- Conference presentation. Maudsley Continuing Care Study (1)
- CRIM-BEHAV-MENT-HEALTH (11)
- Crime-and-Delinquency-Reports; 1981 ADM 81-1011 146 p (1)
- CURR-OPIN-PSYCHIATRY (1)
- Dissertation (2)
- GEN-HOSP-PSYCHIATR (2)
- Harefuah (1)
- HEALTH-BULL-EDINBURGH (2)
- Health Circular (1)
- Health Notice (2)
- Health Service Guidelines (1)

- Hillside-Journal-of-Clinical-Psychiatry (1)
- History-of-Psychiatry (1)
- Hosp-Community-Psychiatry (4)
- The Independent newspaper (1)
- Indian-Journal-of-Clinical-Psychology (1)
- Indian-Journal-of-Psychological-Medicine (1)
- Int-J-Clin-Pract (1)
- INT-J-GERIATR-PSYCHIATRY (3)
- Int-J-Law-Psychiatry (18)
- Int-J-Soc-Psychiatry (4)
- INT-REV-PSYCHIATRY (1)
- IR-J-PSYCHOL-MED (4)
- Isr-J-Psychiatry-Relat-Sci (3)
- Issues-in-Criminological-and-Legal-Psychology (6)
- Issues-in-Mental-Health-Nursing (1)
- J-Am-Acad-Psychiatry-Law (1)
- J-CLIN-FORENSIC-MED (1)
- J-FORENSIC-PSYCHIATRY (4)
- J-Health-Soc-Policy (1)
- J-Med-Ethics (3)
- J-MED-LEG-DROIT-MED (2)
- J-Psychiatr-Ment-Health-Nurs (1)
- J-PSYCHIATR-TREAT-EVAL (2)

- J-PUBLIC-HEALTH-MED (1)
- J-R-Coll-Gen-Pract (1)
- J-R-Soc-Med (1)
- Journal-of-Clinical-Child-Psychology (1)
- Journal-of-Clinical-Psychiatry (1)
- Journal-of-Counseling-and-Development (1)
- Journal-of-Forensic-Sciences (1)
- Journal of Law and Practice (1)
- Journal-of-Mental-Health-Administration (2)
- Journal-of-Operational-Psychiatry (1)
- Journal-of-Primary-Prevention (1)
- The Journal of Social Welfare and Family Law (2)
- Journal-of-Sociology-and-Social-Welfare (1)
- Journal-of-the-National-Association-of-Private-Psychiatric-Hospitals (1)
- Jpn-J-Psychiatry-Neurol (1)
- Kango-Gijutsu (1)
- Lakartidningen (1)
- Lancet (7)
- Law and Human Behaviour (1)
- Law-Med-Health-Care (1)
- MED-J-AUST (2)
- Med-Law (10)
- Med-Leg-J (1)

- Med-Sci-Law (39)
- Mental-and-Physical-Disability-Law-Reporter (3)
- Mental-Disability-Law-Reporter (1)
- Mental-Health-in-Australia (2)
- N-Z-Med-J (5)
- New Community (1)
- New-Directions-for-Mental-Health-Services (1)
- New England Journal of Medicine (1)
- New Law Journal (1)
- New Statesman and Society (1)
- Nordisk-Psykiatrisk-Tidsskrift (1)
- Nurs-Manag-Harrow (1)
- Ontario-Psychologist (2)
- Personality-and-Individual-Differences (1)
- Perspectives-in-Psychiatric-Care (2)
- PHYSIOTHERAPY (1)
- POLICE-SURG (1)
- Practice (1)
- Practitioner (4)
- PSYCHIATR-J-UNIV-OTTAWA (6)
- Psychiatr-Pol (4)
- PSYCHIATR-PSYCHOL-LAW (2)
- Psychiatr-Serv (2)

- Psychiatria-Hungarica (1)
- Psychiatria-Polska (1)
- Psychiatric-Annals (2)
- Psychiatric-Quarterly (2)
- Psychiatrie-de-l'Enfant (1)
- Psychoanalytic-Psychotherapy (1)
- PSYCHOL-MED (6)
- Psychological Bulletin (1)
- Psychotherapy-in-Private-Practice (1)
- R-SOC-HEALTH-J (1)
- Reviews-in-Clinical-Gerontology (1)
- Rivista-Sperimentale-di-Freniatria-e-Medicina-Legale-delle-Alienazioni-Mentali (2)
- Royal College of Psychiatirists (1)
- S-Afr-Med-J (1)
- The Sainsbury Centre for Mental Health : London (1)
- SCOTT-MED-J (1)
- Seishin-Shinkeigaku-Zasshi (3)
- Singapore-Med-J (1)
- Soc-Psychiatry-Psychiatr-Epidemiol (4)
- SOC-SCI-MED (2)
- Social Psychiatry (2)
- Social Services Research (1)
- Thirteenth International Conference on Law and Psychiatry (1)

- TIJDSCHR-PSYCHIATR (2)
- The Times newspaper (1)
- Ugeskr-Laeger (4)

Appendix B: List of journals identified by handsearching

Journal	References
British Journal of Healthcare Management	1
Bulletin of the Royal College of Psychiatrists	31
Community Care	9
Community Medicine	1
Effective Health Care	1
Ethnicity and Health	1
Evaluation Programme Planning	4
Health and Social Care in the Community	1
Health Care Risk Report	1
Health Service Journal	1
Health Services Management Research	1
Health Trends	23
Hospital and Health Services Review	10
http://www.imhl.com/project1.htm	1
International Journal of Health Services	1
Journal of Advanced Nursing	2
Journal of Health Politics, Policy and Law	1
Journal of Mental Health	2
Journal of the Royal Society of Health	1
Mental Health Nursing	3
Network	1
Nursing Mirror	1
Nursing Standard	4
Nursing Times	7
Openmind	2
Police Journal	2
Police Review	2
Psychiatric Bulletin	117
Psychiatric Care	1
PULSE	2
Research, Policy and Planning	2
Social Policy and Administration	1
Social Work Today	10

Appendix C: List of all organisations contacted/written to

- Care Programme Approach Association
- Clinical Audit Association
- College of Health
- Department of Health
- Health line
- Home Office
- Institute of Mental Health Practitioners
- Mental Health Act Commission
- Mental Health Foundation
- Mental Welfare Commission
- Mind
- National Centre for Clinical Audit
- National Schizophrenia Fellowship
- National Health Service Executive
- Northern Ireland Office
- Personal Social Services Research Unit (PSSRU)
- Sainsbury Centre for Mental Health
- SANE
- The Scottish Office
- The Welsh Office

Appendix D: The studies included in this review

Chapter 2: The Act as a whole

Methodology	**Number (n=20)**
Cohort study	0
Case-control	2
Cross-section	4
Case-series	7
Focus group	0
Survey	2
Information unavailable	3
Setting of study	
Regional Secure Unit	1
Psychiatric hospital	4
General hospital	2
Regional area	4
England and Wales	1
City/town	2
Thailand	1
Inpatient adolescent unit	1
Information unavailable	2

Chapter 3: Part II of the Act

Sections examined (more than one per study may apply)	**Number (n = 46)**
Section 2	24
Section 3	19
Section 4	14
Section 5(2)	11
Section 5(4)	9
Section 136	4
Part III	4
Information unavailable	1
Methodology	
cohort study	0
case-control	2
cross-section	4
case-series	25
focus group	1
survey	7
Information unavailable	5
Setting of study	
Locked ward	1
Psychiatric hospital	7
General hospital	5
Unspecified type hospital	11
Regional area	9
England and Wales	3
A whole city/town area	2
Psychiatric Advisory Service	1

Other	1
Information unavailable	6

Chapter 4: Part III of the Act

Sections examined (more than one per study may apply)	**Number (n=23)**
Section 35	10
Section 36	5
Section 37	9
Section 37 (4)	1
Section 37 with Section 41 restrictions	4
Section 38	5
Section 47	4
Section 47 with Section 49 restrictions	2
Section 48	5
Section 48 with Section 49 restrictions	4
Part II	7
Information unavailable	5
Methodology	
cohort study	0
case-control	1
cross-section	1
case-series	17
focus group	0
survey	2
Point prevalence study	1
Information unavailable	6
Setting of study	
Regional Secure Unit	1
Medium Secure Unit	1
Locked Ward	1
Psychiatric hospital	1
England and Wales	1
Special Hospital	4
Prison	6
Prison medical service	1
Courts	4
SCU	2
ISU for mentally handicapped	1
Information unavailable	6

Chapter 5: Part X

Sections examined (more than one per study may apply)	**Number (n = 29)**
Section 135	2
Section 136	27
Section 2	2
Section 4	3
Information unavailable	1
Methodology	
cohort study	0
case-control	0
cross-section	0
case-series	16
focus group	0
survey	5
Information unavailable	9
Setting of study	
Locked ward	1
Psychiatric hospital	8
Regional area	3
A whole city/town area	4
Police station	4
Emergency and Assessment Unit	2
Airport	1
Information unavailable	11

Appendix E: Summary of the Act

Part II

Part II of the Mental Health Act allows a person to be compulsorily admitted or detained where this is necessary in the interests of his/her own health or safety and/or for the protection of other people. The relevant sections are Section 2, which allows a person to be admitted to hospital for assessment for a maximum of 28 days; Section 3 which allows a person to be admitted or detained for treatment for a maximum of six months to one year; Section 4 which is used for the emergency admission for assessment only when Sections 2 or 3 cannot be used owing to no available second opinion outside of the hospital; Section 5(2) which is a doctor's holding power for informal patients; and Section 5(4) which is a nurse's holding power for an informal patient for up to 6 hours or until a doctor becomes available (whichever is the earlier).

Part X

Part X of the MHA gives police the power to remove a person to a place of safety pending an assessment by a doctor and approved social worker. The relevant sections being Section 135, which provides a warrant to search for and remove a person from a private residence to a place of safety; and Section 136, which allows removal by police from a public place to a place of safety.

Part III

Part III relates to people involved in criminal proceedings and aims to ensure that those in prison or police custody who are in need of medical treatment for mental disorders receive appropriate care. Relevant sections include Section 35, under which an accused person can be remanded to hospital for report; Section 36, under which the accused person can be remanded to hospital for treatment; Section 37, under which a convicted person can be sent to hospital for treatment; Section 37(4), under which a convicted person can be detained in a place of safety pending admission to hospital for a trial period; Section 44, under which a Section 37 patient can be committed to hospital by a magistrates court pending a crown court hearing for restriction order; Section 46 under which a person can be detained during Her Majesty's Pleasure following an Armed Forces Court Martial; Section 47, under which, a prisoner serving a sentence can be transferred from prison to hospital; Section 48 under which a remand prisoner can be transferred from prison to hospital.

The remaining Parts of the Act deal in detail with specific issues of application and administration, for example, by defining 'mental disorder' as it is used in the context of the Act, defining how and when consent to treatment should be obtained, the role of Mental Health Tribunals, the removal and return of patients within the UK, the management of property and affairs of patients and a range of

miscellaneous issues.

Appendix F: Studies excluded review and reason for exclusion

Five hundred and sixty articles were not included in this review. Seven of those could not be located, and 12 were not collected as they were books related to various mental health topics.

F:1 Studies which are relevant to the Mental Health Act but which do not include data (n=107)

The authors are currently preparing a review of all the articles which, whilst not including data on the Mental Health Act, did include comments and opinions about its use. These articles total **one hundred and seven:**

Allen D, Allen K. Do patients who have been on 'sections' get refused visas? *PSYCHIATR-BULL.* 1994:216-217.

Anand J. GPs' power to remove patients to hospital . *PULSE.* 1992;52:74.

Andoh B. Jurisprudential aspects of the 'right' to retake absconders from mental hospitals in England and Wales. *MED-SCI-LAW.* 1995;35:225-230.

Appelbaum PS. Almost a revolution: an international perspective on the law of involuntary commitment. *J-Am-Acad-Psychiatry-Law.* 1997;25:135-47.

Azuonye IO. Recommended ammendments to the Mental Health Act 1983. *The Bulletin of the Royal College of Psychiatrists.* 1988;12:525-527.

Barnes M. Protecting the rights of detained patients. *Med-Law.* 1996;15:447-53.

Beech D. Some effects of the Children Act 1989 on the Mental Health Act 1983. *Journal of Law and Practice.* 1992;2:67-72.

Bingley W. Law and the mentally disordered. *CURR-OPIN-PSYCHIATRY.* 1991;4:869-871.

BJN. Is the 1983 Mental Health Act out of touch with reality? [editorial]. *Br-J-Nurs.* 1995;4:67-8.

Blackburn R. Are personality disorders treatable? *Issues-in-Criminological-and-Legal-Psychology.* 1983;4:23-36.

Bluglass R. The draft Code of Practice (Mental Health Act 1983) - in pursuit of agreement. *The Bulletin of the Royal College of Psychiatrists.* 1986;10:76-77.

Bluglass R. The Mental Health Act 1983 for England and Wales: contemporary issues and proposals for reform ten years on. *Jpn-J-Psychiatry-Neurol.* 1994;48 Suppl:111-5.

Bluglass R. The Mental Health Act 1983 in practice. *Med-Leg-J.* 1987;55:151-65.

Bluglass R. The origins of the Mental Health Act 1983 - Doctors in the house. *The Bulletin of the Royal College of Psychiatrists.* 1984;8:127-133.

Brahams D. Treatment of uncoperative psychiatric patients in the community: Mental Health act in need of reform. *LANCET.* 1986;1:863-864.

Bridge C. Caring for the mentally ill - time for review? *British Journal of Health Care Management.* 1995;1:98-101.

Briscoe M, Harris B. Compulsory detention in hospital under the Mental Health Act 1983. *BR-MED-J.* 1987;294:1141-1144.

Caldicott F, Mann S. Mental health law: college committed to improving training. Letter. *BR-MED-J.* 1994;308:408-409.

Candy J, Crouch E. Mental Health Act [letter]. *Br-Med-J-Clin-Res-Ed.* 1987;290:324.

Colville L. The Mental Health Act 1983 Draft Code of Practice Mental Health Act Commission's discussion paper on Consent to Treatment. *The Bulletin of the Royal College of Psychiatrists.* 1986;10:220-221.

Congdon RG. The Mental Health Act 1983: A summary of the act and its implications. *COMMUNITY-MED.* 1984;6:149-155.

Cooper. Begging for arrest. *Social Work Today.* 1992;23:14-15.

Crimlisk H, Phelan M. "Reform of the Mental Health Act 1983: An effective tribunal system?": Comment. *BR-J-PSYCHIATRY.* 1995;167:116-117.

Curran C, Bingley W. The Mental Health Act Commission. *PSYCHIATR-BULL.* 1994;18:328-332.

Davies S, Peck E. Recent government policy and legislation: an overview. *PSYCHIATR-BULL.* 1994;18:662-664.

Dimond B. Consent to Treatment by the Mentally Ill and Mentally Handicapped - An anomaly in the Mental Health Act 1983. *The Bulletin of the Royal College of Psychiatrists.* 1983;7:145.

Dorrell S. Crime and Mental Illness. *Journal of the Royal Society of Health.* 1991;111:114-117.

Dunn J, Fernando R. Psychiatric presentations to an accident and emergency department. *PSYCHIATR BULL.* 1989;13:672-674.

Eastman N. Hybrid justice: proposals for the mentally disordered in the Crime (Sentences) Bill. *PSYCHIATR-BULL.* 1997;21:129-131.

Eastman N. Hybrid Orders: an analysis of their likely effects on sentencing practice and on professional psychiatric practice on services . *J-FORENSIC-PSYCHIATRY.* 1996;7:481-494.

Eastman N. Mental health law: Civil liberties and the principle of reciprocity. *BR-MED-J.*

1994;308:43-45.

Eastman N. Mental Health Law. Letter. *BMJ.* 1994;308:1571.

Edeh J. Patients' rights and the Mental Health Act [letter]. *Lancet.* 1987;1:45.

Farmer A. Tribunal Nouveau: A first taste of the Mental Health Act. *The Bulletin of the Royal College of Psychiatrists.* 1984;8:23-24.

Fenton TW. The aftermath of the Mental Health Act 1983: Some preliminary impressions. *The Bulletin of the Royal College of Psychiatrists.* 1984;8:190-192.

Finch J. You've been framed. *Health Service Journal.* 1993;103:28-30.

Gallwey P. The psychotherapy of psychopathic disorder. *CRIM-BEHAV-MENT-HEALTH.* 1992;2:159-168.

Gostin L. Contemporary legal approaches to psychiatry. *Issues-in-Criminological-and-Legal-Psychology.* 1983;4.

Gray DP. Code of practice for the Mental Health Act 1983. Codifying care [editorial]. *Br-Med-J-Clin-Res-Ed.* 1986;292:1220-1.

Grounds A. Commentary on "Inquiries: who needs them?". *PSYCHIATR BULL.* 1997;21:134-135.

Grounds AT. Detention of "psychopathic disorder" patients in special hospitals: Critical issues. *BR-J-PSYCHIATRY.* 1987;151:474-478.

Gunn MJ. Mental handicap: Legal aspects. The Education Act 1981 and the Mental Health Act 1983. *PHYSIOTHERAPY.* 1985;71:216-219.

Hamid W, McCarthy M. Community psychiatric care for homeless people in inner London. *Health Trends.* 1989;21:67-69.

Hamilton JR. Birth of the Mental Health Act 1983. *Br-J-Hosp-Med.* 1984;31:54-7.

Hamilton JR. Chemical castration and consent to treatment. *The Bulletin of the Royal College of Psychiatrists.* 1988;12:493-494.

Hamilton JR. Code of practice for the Mental Health Act 1983. *BR-MED-J.* 1986;292:1219-1220.

Hamilton JR. The management of psychopathic offenders. *Br-J-Hosp-Med.* 1987;38:245-50.

Hamilton JR. Mental Health Act 1983. *Br-Med-J-Clin-Res-Ed.* 1983;286:1720-5.

Hamilton JR. The Mental Health Act Commission. *BR-MED-J.* 1986;292:849-850.

Hamilton JR. Observations of the Mental Health Act 1983. *INT-J-LAW-PSYCHIATRY.* 1983;6:371-380.

Hamilton JR. The provisions of the act: A psychiatrist's view. *Issues-in-Criminological-and-Legal-Psychology.* 1983;4:15-22.

Hodge JE. Addiction to violence: A new model of psychopathy. *CRIM-BEHAV-MENT-HEALTH.* 1992;2:212-223.

Jelley M. Common Law and the 'Code of Practice' - a commentary. *PSYCHIATR-BULL.* 1990;14:449-451.

Joseph PL, Potter M. "Court diversion": Reply. *BR-J-PSYCHIATRY.* 1993;163:413-414.

Josse SE. Applying the 1959 Mental Health Act. *Practitioner.* 1983;227:91-7.

Kastrup M. Who became revolving door patients? *Acta Psychiatr. Scand.* 1987;76:80-88.

Kendell RE. The Mental Health Act Commission's "guidelines": a further threat to psychiatric research. *Br-Med-J-Clin-Res-Ed.* 1986;292:1249-50.

Kirkpatrick A, Feldman P. Is anyone out there listening? Official enquiries into psychiatric hospitals. *HOSP-HEALTH-SERV-REV.* 1983;79:17-21.

Lee Evans M. The 1983 Mental Health Act and the treatment of abnormal offenders. *Issues-in-Criminological-and-Legal-Psychology.* 1986;9:15-30.

legal correspondent. Compulsory treatment of the mentally ill. *BR-MED-J.* 1986;292:888-889.

Manning M. The Mental Health Act five years on. *Social Work Today.* 1988;20:14-16.

Mapp S, Murphy E, Gough M. Stuck in the past. *Community Care.* 1995;1055:16-17.

Mason T, Jennings L. The Mental Health Act and professional hostage taking. *Med-Sci-Law.* 1997;37:58-68.

Milburn A. Labour's approach to mental health policy. *Mental Health Nursing.* 1996;16:8-10.

Millar B. Cross Section. *Social Work Today.* 1992;23:12.

MILMIS Project Group. Monitoring Inner London Mental Illness Services. *PSYCHIATR-BULL.* 1995;19:276-280.

Muijen M. Inquiries: who needs them? *PSYCHIATR BULL.* 1997;21:132-133.

Noble P. Mental health services and legislation: An historical review. *MED-SCI-LAW.* 1981;21:16-24.

O'Donovan C. Mental Health Act: Alleged unlawful detention. *The Bulletin of the Royal College of Psychiatrists.* 1987;11:224-225.

Parikh P, Stern R. Why do patients occupy psychiatric beds? A pilot study. *PSYCHIATR-BULL.* 1990;14:657-660.

Peay J. The Mental Health Act 1983 (England and Wales): Legal safeguards in limbo. American Society of Law & Medicine 1st International Conference on Health Law & Ethics (1986, Sydney, Australia). *Law-Med-Health-Care.* 1986;14:180-189.

Personal Social Services Research Unit. Mental Health Research Review (5). 1998;5.

Pink V. One minute wisdom. Mental Health Act section orders could be more effectively policed. *Nurs-Stand.* 1993;8:41.

Poynton A, Bridges PK, Bartlett JR. Psychosurgery in Britain now. *BR-J-NEUROSURG.* 1988;2:297-306.

Prins H. The Mental Health Act and professional hostage taking [letter]. *Med-Sci-Law.* 1997;37:181-2.

Prins HA. Attitudes towards the mentally disordered. *MED-SCI-LAW.* 1984;24:181-191.

Reeves RW. Treating mentally disordered prisoners. Mental Health Act Commission should visit prisons [letter]. *BR-MED-J.* 1995;311:1641.

Renshaw J. Good practices in Mental Health. *PSYCHIATR BULL.* 1989;13:191-192.

Ridley S, Rowan. K. Be wary of occupancy figures. *Health Trends.* 1997;29:100-105.

Robertson G. Changes in the use of the criminal provisions of the 1959 Mental Health Act. *Issues-in-Criminological-and-Legal-Psychology.* 1984;6:17-27.

Robertson G. Objections to the present system. *CRIM-BEHAV-MENT-HEALTH.* 1992;2:114-123.

Robin A. The code of practice and parliamentary intention concerning short term treatment orders. *PSYCHIATR-BULL.* 1991;15:488-489.

Rohde P. Compulsory treatment in the community: is it authorized under the Mental Health Act? *The Bulletin of the Royal College of Psychiatrists.* 1984;8:148-151.

Rohde PD. Mental Health Act Commission and the code of practice. *Br-Med-J-Clin-Res-Ed.* 1983;287:1318-9.

Rosen BK. Mental illness and the general practitioner. *PRACTITIONER.* 1984;228:1155-1157.

Royal College of Psychiatrists. Comments of the Royal College of Psychiatrists on the Mental Health Act 1983 Draft Code of Practice. *The Bulletin of the Royal College of Psychiatrists.* 1986;10:194-195.

Royal College of Psychiatrists. The Mental Health Act Draft Code of Practice. *The Bulletin of the Royal College of Psychiatrists.* 1987;11:63-67.

Rumsey H. Hot Seat. *Health Service Journal.* 1996;106:32-33.

Scott-Moncrieff L. The Mental Health Act 1983. *New Law Journal*. 1985;135:299-300.

Shah A. Displacement of the nearest relative under the Mental Health Act 1983. *MED-SCI-LAW*. 1996;36:325-327.

Shapland J, Williams T. Legalism revived: New mental health legislation in England. *INT-J-LAW-PSYCHIATRY*. 1983;6:351-369.

Shapland J, Williams T. The scope of the new legislation. *Issues-in-Criminological-and-Legal-Psychology*. 1983;4.

Silberston D. Admission under the Mental Health Act [letter; comment]. *Lancet*. 1993;341:440.

Sinason M. Letter to the editor: Response. *Psychoanalytic-Psychotherapy*. 1994;8:94-96.

Sinclair L. Mental Health Act and the code of practice [letter]. *Br-Med-J-Clin-Res-Ed*. 1984;288:149.

Singh TH. Mental Health Act: definition of severe mental impairment and mental impairment and its implications [letter]. *Br-Med-J-Clin-Res-Ed*. 1984;288:149-50.

Soothill K, Kupituksa P, Macmillan F. Compulsory hospital admissions: Dangerous decisions? *MED-SCI-LAW*. 1990;30:17-25.

Szmukler GI. The Mental Health (Ammendment) Act 1982: Will it make a difference? *The Bulletin of the Royal College of Psychiatrists*. 1983;7:158-159.

Thomas L. The number of in patients formally detained in hospital under the Mental Health Act [editorial]. *Nurs-Stand*. 1997;11:1.

Timms PW, Fry AH. Homelessness and mental illness. *Health Trends*. 1989;21:70-71.

Travers RF, Brabbins CJ. Court diversion. *BR-J-PSYCHIATRY*. 1993;163:412-413.

Twining TC. Psychology, law and mental competence in the elderly. *Bulletin-of-the-British-Psychological-Society*. 1983;36:198-200.

Weleminsky J, Birley J. Mental Health Act 1983: Correspondence between the President and the Director of the National Schizophrenia Fellowship. *PSYCHIATR-BULL*. 1990;14:235-236.

Wells W. Negligence and the mental health act. *LANCET*. 1985;2:547.

Williams T. Restriction in Roehampton. *OPENMIND*. 1990;45:15.

Williams TI, Shapland J. The Code of Practice: Strengthening the legalist philosophy? *INT-J-LAW-PSYCHIATRY*. 1988;11:1-12.

Woolrych, R. The legal issues of dealing with cases of abuse. *Social Work Today*. 1987; 19: 11-12

F 2: Papers detailing results of studies on mental health Acts and Laws in other countries (n=220)

NGRI transfer procedures ruled constitutional. *Mental-and-Physical-Disability-Law-Reporter*. 1984;8:98.

[Revision of the Mental Health Act]. *Seishin-Shinkeigaku-Zasshi*. 1986;88:629-704.

Statement by Senator Edward M. Kennedy: The Mental Health Systems Act. *J-PSYCHIATR-TREAT-EVAL*. 1980;2:69-71.

Symposium on the implications for nursing of the Mental Health (Scotland) Act 1984. *Nurs-Stand*. 1984:9.

Anthony WA, Cohen M, Kennard W. Understanding the current facts and principles of mental health systems planning. *American-Psychologist*. 1990;45:1249-1252.

Appelbaum PS. England's new commitment law. *HOSP-COMMUNITY-PSYCHIATRY*. 1985;36:705-706, 713.

Arboleda F. J. , Crisanti A, Holley HL. The effects of changes in the law concerning mentally disordered offenders: the Alberta experience with Bill C-30 [see comments]. *CAN-J-PSYCHIATR*. 1995;40:225-33.

Arboleda F. J. , Holly H. How Alberta psychiatrists view commitment criteria and the problem of predicting dangerousness. *CAN-J-PSYCHIATR*. 1984;29:38-41.

Ashley M, Sestak RM, Roth LH. Legislating human rights: Informed consents and The Pennsylvania Mental Health Procedures Act. *BULL-AM-ACAD-PSYCHIATR-LAW*. 1980;8:133-151.

Atkinson JM, Harper Gilmour W, Dyer JAT, Hutcheson F, Patterson L. Consultant's views of Leave of Absence and Community Care Orders in Scotland. *PSYCHIATR-BULL*. 1997;21:91-24.

Attah Johnson FY. Mental Health Care and the law in developing countries: The independent state of Papua New Guinea. *MED-LAW*. 1988;7:359-363.

Bagby RM. The effects of legislative reform on admission rates to psychiatric units of general hospitals. *INT-J-LAW-PSYCHIATRY*. 1987;10:383-394.

Barbato A, Terzian E, Saraceno B, De Luca L, Tognoni G. Outcome of discharged psychiatric patients after short inpatient treatment: An Italian collaborative study. *SOC-PSYCHIATRY-PSYCHIATR-EPIDEMIOL*. 1992;27:192-197.

Barbato A, Terzian E, Saraceno B, Montero Barquero F, Tognoni G. Patterns of aftercare for psychiatric patients discharged after short inpatient treatment. An Italian collaborative study. *Soc-Psychiatry-Psychiatr-Epidemiol*. 1992;27:46-52.

Basse F, Basse E, Muller C, Paniel A, Everett A. Caring for mentally disordered offenders in Metz.

Mental Health Nursing. 1994;14:16-19.

Baxter EA, Spence ND, Goldney RD, Bennetts KJ. Compulsory admission of the mentally ill: Adequacy of documentation. *MED-J-AUST*. 1986;145:66-68.

Bell S. The Mental Health (Compulsory Treatment and Assessment) Act. *Community-Mental-Health-in-New-Zealand*. 1992;7:16-22.

Bellack AS. Programma di trattamento comprensivo per la schizofrenia. (A comprehensive treatment program for schizophrenics.) First International Convention on the Social Learning of Psychotics: Elimination of the psychiatric hospital--utopia or reality? (1984, Reggio nell'Emilia, Italy). *Rivista-Sperimentale-Di-Freniatria-e-Medicina-Legale-Delle-Alienazioni-Mentali*. 1985;109:1324-1337.

Benoit MB. The role of the mental health practitioner in child advocacy in the school system. 1988.

Beveridge A. Psychology of compulsory detention. *PSYCHIATR-BULL*. 1998;22:115-117.

Birleson P. Legal rights and responsibilities of adolescents and staff in Victorian Child and Adolescent Mental Health Services. *Aust-N-Z-J-Psychiatry*. 1996;30:805-12.

Borzecki M, Wormith JS. The criminalization of psychiatrically ill people: A review with a Canadian perspective. *PSYCHIATR-J-UNIV-OTTAWA*. 1985;10:243-247.

Bottomley S. Mental health law reform and psychiatric deinstitutionalization: The issues in New South Wales. *INT-J-LAW-PSYCHIATRY*. 1987;10:369-382.

Boyd WD, Woodside M, Zealley AK. Psychogeriatric consultation: A review of 100 home and hospital visits in Edinburgh. *HEALTH-BULL-EDINBURGH*. 1979;37:202-207.

Brinded PM, Grant FE, Smith JE. The spectre of criminalization: remand admissions to the Forensic Psychiatric Institute, British Columbia, 1975-1990. *Med-Sci-Law*. 1996;36:59-64.

Brook OH. Changing patterns in the legal position of psychiatric patients after admission, a cohort study. From the Central Registration of Patients admitted in general mental hospitals. *TIJDSCHR-PSYCHIATR*. 1985;27:491-509+511.

Brown P, Smith CJ. Mental patients' rights: An empirical study of variation across the United States. *INT-J-LAW-PSYCHIATRY*. 1988;11:157-165.

Brunton W. Mental health law in New Zealand: Some sources and traditions. *Community-Mental-Health-in-New-Zealand*. 1985;2:70-83.

Burra P, Kimberley R, Miura C. Mental competence and consent to treatment. *CAN-J-PSYCHIATR*. 1980;25:251-253.

Burti L, Mosher L. Training psychiatrists in the community: a report of the Italian experience. *American Journal of Psychiatry*. 1986;143:1580-4.

Cahn R. Les structures intermediaires: Panorama et bilan. (Halfway houses: Panorama and balance sheet.). *Psychiatrie-De-l'Enfant.* 1983;26:257-298.

Chamberlin J, Rogers JA. Planning a community-based mental health system: Perspective of service recipients. *American-Psychologist.* 1990;45:1241-1244.

Chan MP, Conacher GN. Legally untreatable--a new category of long stay patient? *CAN-J-PSYCHIATR.* 1994;39:433-5.

Chandrasena R, Smith S. Regional Review Boards of Ontario: a medico-legal review. *CAN-J-PSYCHIATR.* 1986;31:643-8.

Chaplow DG, Chaplow R, Maniapoto WT. Addressing cultural differences in institutions: Changing health practices in New Zealand. *CRIM-BEHAV-MENT-HEALTH.* 1993;3:307-321.

Chiswick D. The Criminal Procedure (Scotland) Act 1995: new legislation for mentally disordered offenders. *PSYCHIATR-BULL.* 1997;21:110-112.

Chiswick D. Section 31 of the Mental Health (Scotland) Act 1960. Compulsory crisis intervention? *INT-J-LAW-PSYCHIATRY.* 1980;3:435-441.

Chiswick D, Shubsachs APW, Novosel S. Reprosecution of patients found unfit to plead: a report of anomalies in procedure in Scotland. *PSYCHIATR-BULL.* 1990;14:208-209.

Christensen AM, Rogne TA. [Involuntary admissions and other compulsions in psychiatry. Patients' knowledge of their rights and ability to receive information concerning these matters]. *Ugeskr-Laeger.* 1994;156:5300-3.

Church OM. Emergence of training programs for asylum nursing at the turn of the century. *Advances-in-Nursing-Science.* 1985;7:35-46.

Cox AJ. Deinstitutionalization and the community mental health movement. 1991.

Cox GB, Allen DG, Brown L, Gilchrist LD, et al. Recommendations for state-wide evaluations: Lessons relearned. *EVAL-PROGRAM-PLANN.* 1994;17:97-101.

Currier GW. A survey of New Zealand psychiatrists' clinical experience with the Mental Health (Compulsory Assessment and Treatment) Act of 1992. *N-Z-Med-J.* 1997;110:6-9.

Curtin JJ, Wickware DM. Update on how the Mental Health Act of Ontario is working. *PSYCHIATR-J-UNIV-OTTAWA.* 1982;7:235-239.

Dabrowski S. [Changes in the proposed mental health act]. *Psychiatr-Pol.* 1987;21:121-7.

Dabrowski S. [Mental health act. Basic problems and introduction into practice]. *Psychiatr-Pol.* 1995;29:721-30.

Dabrowski S, Gerard K, Kolinska F, et al. Involuntary hospitalization in Poland. *PSYCHIATR-J-UNIV-OTTAWA.* 1979;4:322-328.

Dahl AA, Borge N, Spydslaug A. Tvangsinnleggelse til observasjon. En studie av innleggelser etter 3 i Lov om psykisk helsevern. (Compulsory commitment for observation: A study of commitment based on Section 3 of the Norwegian Mental Health Act.). *Nordisk-Psykiatrisk-Tidsskrift.* 1985;39:381-387.

Daly OE. Detention - the grey area: problems in the use of the Mental Health (Northern Ireland) Order. *PSYCHIATR BULL.* 1989;13:12-14.

Daly OE, Compton SA. Variations in the use of the Mental Health (NI) Act 1961. *MED-SCI-LAW.* 1988;28:171-174.

Dawson JB, Abbott MW, Henning MA. Who gets committed: demographic and diagnostic data. *N-Z-Med-J.* 1987;100:142-5.

De Salvia D, Barbato A. Recent trends in mental health services in Italy: an analysis of national and local data [see comments]. *CAN-J-PSYCHIATR.* 1993;38:195-202.

Deasy LC, Steele CI. An analysis of a state hospital population subject to release under Florida law. *HOSP-COMMUNITY-PSYCHIATRY.* 1976;27:42-44.

Dedman P. Community Treatment Orders in Victoria. *PSYCHIATR-BULL.* 1990;14:462-464.

Doutney C. Mental health law reform: Advance towards enlightenment or denial of reality? *AUST-N-Z-J-PSYCHIATRY.* 1986;20:266-275.

Doyle H, Delaney W. Police referral of compulsory admissions: A comparison study. *Irish Journal of Psychological Medicine.* 1994;11:116-119.

Durham J. The gravely inadequate definition of a "mentally ill person" in the Mental Health Act (New South Wales) 1983. *Aust-N-Z-J-Psychiatry.* 1988;22:43-68.

Durham J. Inadequate provision for electroconvulsive therapy in the New South Wales Mental Health Act 1983. *Aust-N-Z-J-Psychiatry.* 1988;22:404-11.

Ebben PA, Bliss D, Perlman B. Problems and issues in community mental health service delivery in the 1990s. *Community-Ment-Health-J.* 1991;27:225-9.

Errington MR. The operation of the Mental Health Act, 1983 (NSW). *Aust-N-Z-J-Psychiatry.* 1986;20:278-92.

Falicki Z, Rutkiewicz W. Controversial problems in the mental health act. *PSYCHIATR-POL.* 1996;30:561-567.

Falicki Z, Rutkiewicz W. [A discussion of problems in interpretation of the Mental Health Act]. *Psychiatr-Pol.* 1996;30:561-7.

Farren C, McLoughlin D, Clare A. Procedures for involuntary admission to public and private psychiatric facilities. *IR-J-PSYCHOL-MED.* 1992;9:96-100.

Felipe Russo N. Time to focus upon women: The Mental Health Systems Act. *Clinical-Psychologist*. 1979;33:18-19.

Fenton GW, Ballinger BR, Ballinger CB, Naylor GJ. Medical audit in a Scottish psychiatric service. *PSYCHIATR-BULL*. 1990;14:136-139.

Fernando MLD, Cooper AJ, Cernovsky Z, Bailey C, Velamoor VR. The impact of the amended Ontario Mental Health Act (Bill 7) on patients discharging themselves from hospital against medical advice. *CAN-J-PSYCHIATR*. 1990;35:77.

Flamm GH. General hospital psychiatry: Structure or concept? *GEN-HOSP-PSYCHIATR*. 1981;3:315-319.

Frankenburg FR. The history of the confinement of the mentally ill in Ontario. *PSYCHIATR-J-UNIV-OTTAWA*. 1982;7:240-243.

Friedman RM. Major issues in mental health services for children. Sixth Annual Meeting of the American College of Mental Health Administration (1986, San Diego, California). *Administration-in-Mental-Health*. 1986;14:6-13.

Froese AP. Minors' right to psychiatric treatment. Special Issue: Child and adolescent psychiatry. *CAN-J-PSYCHIATR*. 1991;36:452-455.

Ganesvaran T, Shah AK. Psychiatric in-patient suicide rates: a 21-year study. *Med-Sci-Law*. 1997;37:202-9.

Garzotto N, Burti L, Siciliani O, et al. Reported prevalence of alcohol dependence in South Verona: A case register study. *COMPR-PSYCHIATRY*. 1984;25:438-445.

Gaviria M, Stern G. Problems in designing and implementing culturally relevant mental health services for Latinos in the U.S. *SOC-SCI-MED*. 1980;14B:65-71.

Goldston SE. Prevention planning at the federal level. 1987.

Goldston SE. Primary prevention programming from the federal perspective: A progress report. *Journal-of-Clinical-Child-Psychology*. 1979;8:80-83.

Gopalakrishnan G. Mental Health Act of 1987: Looking beyond law. *Indian-Journal-of-Psychological-Medicine*. 1990;13:75-80.

Gorman M. Community absorption of the mentally ill: The new challenge. *Community-Ment-Health-J*. 1976;12:119-127.

Goto A, Iwadate T, Asano H, et al. [The present state of mental health services in the Tohoku district. II. Some changes after the enforcement of the Mental Health Act]. *Seishin-Shinkeigaku-Zasshi*. 1992;94:368-85.

Gove WR, Fain TA. A comparison of voluntary and committed psychiatric patients. *Archives of General Psychiatry*. 1977;34:669-676.

Grob GN. From hospital to community: Mental health policy in modern America. Symposium: Community psychiatry then and now (1991, Albany, New York). *Psychiatric-Quarterly*. 1991;62:187-212.

Hall W, Flaherty B. Involuntary admissions initiated by police officers under the New South Wales Mental Health Act, 1958. *Mental-Health-in-Australia*. 1982;1:31-33.

Hall W, Flaherty B. The Schedule 2 certificate under the New South Wales Mental Health Act, 1958. *Mental-Health-in-Australia*. 1982;1:36-43.

Hanig D, Perry RD, Johnson SS. Mental health reform in Washington State: The first steps. *EVAL-PROGRAM-PLANN*. 1994;17:37-42.

Hapenney S. The impact of P.L. 93-641, the National Health Planning and Resources Development Act, upon health and mental health programming. *EVAL-PROGRAM-PLANN*. 1978;1:79-81.

Hasle NJ. [The appointed guardian--a counsellor of the forensic psychiatric patient?]. *Ugeskr-Laeger*. 1994;156:7368-72.

Hasle NJ. [Children and adolescents under 18 years of age admitted to a psychiatric department for adults]. *Ugeskr-Laeger*. 1997;159:4649-53.

Heinik J, Kimhi R. Psychiatric hospitalization of senile and arteriosclerotic dementia patients by commitment order under the 1991 Israeli Mental Health Act. *Med-Law*. 1995;14:471-8.

Heinik J, Levy A. [Enforced psychiatric hospitalization for dementia by the district psychiatrist]. *Harefuah*. 1996;130:173-7; 223.

Hoffman BF. Assessing the competence of people to consent to medical treatment: A balance between law and medicine. *MED-LAW*. 1990;9:1122-1130.

Hoffman BF, Srinivasan J. A study of competence to consent to treatment in a psychiatric hospital. *CAN-J-PSYCHIATR*. 1992;37:179-82.

Holmberg G, Kristiansson M. [Screening of persons referred to forensic psychiatry. Many of them were in contact with psychiatric services before the offence]. *Lakartidningen*. 1997;94:4071-5.

Humphreys MS. Persuasion, coercion, medical paternalism or the Mental Health Act: The dilemma of detention in the general hospital. *SCOTT-MED-J*. 1992;37:146-148.

Humphreys M. Junior psychiatrists and emergency compulsory detention in Scotland. *INT-J-LAW-PSYCHIATRY*. 1994;17:421-429.

Humphries MS. Non-consultant psychiatrists' knowledge of emergency detention procedures in Scotland. *PSYCHIATR-BULL*. 1997;21:631-635.

Jaworowski S. The ethical issues of enforcing parents' participation in the psychiatric treatment of

minors. *Isr-J-Psychiatry-Relat-Sci.* 1997;34:37-43.

Jaworowski S, Nachmias S, Zabow A. Enforced psychiatric treatment of minors in Israel: the interface between the Mental Health Act and the Youth Law. *Isr-J-Psychiatry-Relat-Sci.* 1995;32:114-9.

Jaychuk G, Manchanda R, Galbraith DA. Consent to treatment: loophole in the Ontario Mental Health Act. *CAN-J-PSYCHIATR.* 1991;36:594-6.

Jeffries JJ, Rakoff VM. ECT as a form of restraint. *CAN-J-PSYCHIATR.* 1983;28:661-663.

Kaliski SZ, Koopowitz LF, Reinach SG. Survey of certification practices for patients admitted to Sterkfontein Hospital. *S-Afr-Med-J.* 1990;77:37-40.

Kane JM, Quitkin F, Rifkin A, Wegner J, Rosenberg G, Borenstein M. Attitudinal changes of involuntarily committed patients following treatment. *Archives of General Psychiatry.* 1983;40:374-377.

Kearney M. Confidentiality in group psychotherapy. *Psychotherapy-in-Private-Practice.* 1984;2:19-20.

Kelsey J. Bi-culturalism, access to justice and the Mental Health Act. *Community-Mental-Health-in-New-Zealand.* 1988;4:28-44.

Kennedy EM. Community-based care for the mentally ill: Simple justice. *American-Psychologist.* 1990;45:1238-1240.

Klerman GL. Patient reentry into the community: The federal viewpoint. *Journal-of-the-National-Association-of-Private-Psychiatric-Hospitals.* 1979;11:5-11.

Klijnsma. Patient advocacy in the Netherlands. *PSYCHIATR-BULL.* 1993;17:230-231.

Koenig I. Report of the Committee on Psychology and the Law: Mental Health Act review. *Ontario-Psychologist.* 1974;5:45-54.

Kolb LC. Research and its support under the National Mental Health Act. 1949 [classical article]. *American Journal of Psychiatry.* 1994;151:210-5.

Kortmann FAM. Compulsory admission in psychiatry; rights of patients and Code of Practice. *TIJDSCHR-PSYCHIATR.* 1995;37:759-768.

Koryagin A. Compulsion in psychiatry: blessing or curse? *PSYCHIATR-BULL.* 1990;14:394-398.

Kramp P. [Decrees of dangerousness]. *Ugeskr-Laeger.* 1993;155:939-46.

Kunjukrishnan R, Bradford JM. Interface between the criminal justice system and the mental health system in Canada. *PSYCHIATR-J-UNIV-OTTAWA.* 1985;10:24-33.

Kuo Sh. Forensic psychiatry in Taiwan. *INT-J-LAW-PSYCHIATRY.* 1983;6:457-472.

Kupituksa P, Macmillan JF, Soothill KL. Compulsory admission to mental hospital in Thailand and England. *PSYCHIATR BULL*. 1989;13:355-357.

Laffont I, Priest RG. A comparison of French and British mental health legislation. *PSYCHOL-MED*. 1992;22:843-850.

Lee JW. The Mental Health Act 1992 [letter]. *N-Z-Med-J*. 1996;109:173.

Leong GB. Psychiatrists and community mental health centers: Can their relationship be salvaged? *HOSP-COMMUNITY-PSYCHIATRY*. 1982;33:309-310.

Levy A. The District Psychiatrist Institution: A criticism. *MED-LAW*. 1989;8:15-20.

Levy A. New subordinate psychiatric legislation in Israel. *Med-Law*. 1995;14:307-12.

Levy A, Davidson S. Legislation concerning patients' rights in Israel and in Britain. *ISR-J-PSYCHIATRY-RELAT-SCI*. 1986;23:147-156.

Levy A, Davidson S. The rights of the mental patient in Israel. *MED-LAW*. 1984;3:405-420.

Lieff S, Maindonald K, Shulman K. Issues in determining financial competence in the elderly. *CAN-MED-ASSOC-J*. 1984;130:1293-1296.

Liverpool N. A survey of mental health legislation in the Eastern Caribbean. *INT-J-LAW-PSYCHIATRY*. 1986;8:119-131.

Long BB. A conversation with Rosalynn Carter. *American-Psychologist*. 1986;41:830-833.

Loudon JB, Mackay AVP, Kendell RE. Mental Health Records: A good practice statement.

Luckey JW, Berman JJ. Effects of new commitment laws on the mental health system. *American-Journal-of-Orthopsychiatry*. 1981;51:479-483.

Lyon Levine M, Levine ML, Zusman J. Developments in Patients' Bill of Rights since the Mental Health Systems Act. *Mental-and-Physical-Disability-Law-Reporter*. 1985;9:146-153.

Lyon MA, Levine ML, Zusman J. Patients' bills of rights: A survey of state statutes. *Mental-Disability-Law-Reporter*. 1982;6:178-201.

Malla A. Investigation of the criteria for involuntary admission to a general hospital. *Can-Med-Assoc-J*. 1988;139:749-52.

Malla A, Norman RMG, Helmes E. Factors associated with involuntary admission to psychiatric facilities in Newfoundland. *Can Med Assoc J*. 1987;136:1166-1171.

Manchanda R, Fernando ML, Galbraith DA. Consent to treat: clinical and legal implications. *CAN-J-PSYCHIATR*. 1989;34:60-2.

Marcos LR, Cohen NL. Taking the suspected mentally ill off the streets to the public general hospitals. *New England Journal of Medicine*. 1986;315:1158-1161.

Martin BA, Jacobsen PM. Electroconvulsive therapy and brain damage: The Ontario Supreme Court hearing of the evidence. *CAN-J-PSYCHIATR.* 1986;31:381-386.

Martinez HL, Ruiz P. A socio-epidemiological analysis of an urban ghetto day hospital program. *J-PSYCHIATR-TREAT-EVAL.* 1979;1:5-11.

Mashino H. The practice of community mental health. *ASIAN-MED-J.* 1980;23:781-788.

Mastroeni A, Travasso B, Cecere F, Faggioli L. Modelli di trattamento e domanda psichiatrica: Dati epidemiologici da un registro dei casi. (Treatment patterns and the use of psychiatric. *Rivista-Sperimentale-Di-Freniatria-e-Medicina-Legale-Delle-Alienazioni-Mentali.* 1986;110:848-862.

Matthews K, Milne S. How and when to apply the Mental Health Act. *Practitioner.* 1994;238:398, 401-4.

McCarthy M. Psychiatric care in Italy: Evidence and assertion. *HOSP-HEALTH-SERV-REV.* 1985;81:278-280.

McCormick WO. Involuntary commitment in Ontario: Some barriers to the provision of proper care. *CAN-MED-ASSOC-J.* 1981;124:715-717.

McCreadie RG. The operation of the Mental Health (Scotland) Act 1984 in one psychiatric hospital. *HEALTH-BULL-EDINBURGH.* 1989;47:204-6.

McCready J, Merskey H. Compliance by physicians with the 1978 Ontario Mental Health Act. *CAN-MED-ASSOC-J.* 1981;124:719-724.

McCready J, Merskey H. Reasons for involuntary commitment in Manitoba and Ontario. *CAN-J-PSYCHIATR.* 1984;29:72.

McGarry AL, et al. Civil commitment and social policy: An evaluation of the Massachusetts Mental Health Reform Act of 1970. *Crime-and-Delinquency-Reports; 1981 ADM 81-1011 146 p.* 1981.

McKechnie AA, Corser A, McMillan VR. Outcome of patients committed to hospital under the Mental Health (Scotland) Act 1960. *Br-J-Psychiatry.* 1986;148:33-7.

McLay WDS. Mental health (Scotland) act 1984. Some practical points. *POLICE-SURG.* 1986;29:37-41.

McShane W, Redoutey LJ. Community hospitals and community mental health agencies: Partners in service delivery. Annual Meeting of the Association of Mental Health Administrators (1986, San Francisco, California). *Journal-of-Mental-Health-Administration.* 1987;14:1-6.

Menuck M, Littmann SK. Involuntary admission to hospital and treatment in Ontario: Is pessimism among physicians warranted? *CAN-MED-ASSOC-J.* 1982;126:1168-1171.

Miedema B. A critique of 'Oversimplified images: Comments on ...'. *CAN-J-COMMUNITY-MENT-*

HEALTH. 1995;14:133-136.

Miller A. The Ontario Mental Health Act, 1978. A comment on its application. *CAN-J-PSYCHIATR.* 1979;24:515-516.

Morosini PL, Repetto F, De Salvia D, Cecere F. Psychiatric hospitalization in Italy before and after 1978. *Acta-Psychiatr-Scand-Suppl.* 1985;316:27-43.

Mullen PE. Reform of the Mental Health Act. *N-Z-Med-J.* 1985;98:230-1.

Munetz MR, Kaufman KR, Rich CL. Modernization of a mental health act: II. Outcome effects. *Journal-of-Clinical-Psychiatry.* 1981;42:333-337.

Murphy JW, Pardeck JT, Chung WS, Choi JM. Symbolic violence and social control in the post-Total Institution era. *Journal-of-Sociology-and-Social-Welfare.* 1994;21:115-132.

Musto DF. Whatever happened to community mental health? *Psychiatric-Annals.* 1977;7:30-55.

Nelson JK, Schilke DA. The evolution of psychiatric liaison nursing. *Perspectives-in-Psychiatric-Care.* 1976;14:60-65.

O'Brien TA, Mellsop GW, McDonald KP, Ruthe CB. A one year analysis of appeals made to mental health review tribunals in New Zealand. *Aust-N-Z-J-Psychiatry.* 1995;29:661-5.

O'Loughlin F, Webb M. Controlled assessment of alcoholics admitted involuntarily to a general psychiatric hospital. *IR-J-PSYCHOL-MED.* 1996;13:140-143.

Okada Y. [Criticism of the Mental Health Act, 1987]. *Seishin-Shinkeigaku-Zasshi.* 1989;91:170-8.

Okin RL. The relationship between legal status and patient characterisitcs in state hospitals. *American Journal of Psychiatry.* 1986;143:1233-1237.

Page S. New civil commitment legislation. The relevance of commitment 'criteria'. *CAN-J-PSYCHIATR.* 1980;25:646-650.

Page S. Civil commitment: Continuing confusing conjecture concerning "criteria.". *Ontario-Psychologist.* 1983;15:36-39.

Pardeck JT, Murphy JW, Chung WS. An exploration of factors associated with clients prematurely exiting psychiatric treatment: Implications for the Community Mental Health Centers Act. *J-Health-Soc-Policy.* 1995;7:87-96.

Pardes H. The demise of a major innovation: Carter's 1980 Community Mental Health Systems Act in Reagan's hands. 1990.

Paredes J, Kanachowski A, Ledwidge B, Stoutenburg K, Beyerstein D. The validity of commitment certificates in British Columbia. *CAN-J-PSYCHIATR.* 1990;35:305-10.

Parker N. The Garry David case. *AUST-N-Z-J-PSYCHIATRY.* 1991;25:371-374.

Penner S. An evolving managed care system: Public mental health services in San Francisco. Special Issue: Public sector planning for managed mental health care. *ADM-POLICY-MENT-HEALTH.* 1995;22:273-287.

Perera C, Wilson B. The treatment and care of mentally ill offenders in Victoria, Australia. *PSYCHIATR-PSYCHOL-LAW.* 1996;3:47-61.

Pergami A. Towards an implementation of the Italian model of community psychiatry. *PSYCHIATR-BULL.* 1992;16:90-92.

Perry RD, Hoff BH, Gaither DS. The process study component of mental health evaluation. *EVAL-PROGRAM-PLANN.* 1994;17:43-46.

Petch A, Simic P, Smith R. Moving forward in mental health. *Social Work Today.* 1990;21:22.

Petr CG, Pierpont J. Early implementation of legislative children's mental health reform: The Minnesota/Hennepin County experience. *Journal-of-Mental-Health-Administration.* 1992;19:195-206.

Pisztora F. / A short history of Hungarian psychiatry during the Austo- Hungarian Empire and between the World Wars (1867-1944), Part II. *Psychiatria-Hungarica.* 1993;8:125-137.

Ramon S. Psichiatria democratica: a case study of an Italian community mental health service. *Int-J-Health-Serv.* 1983;13:307-24.

Ramshorn MT. The major thrust in American psychiatry: Past, present, and future. *Perspectives-in-Psychiatric-Care.* 1983;21:148-154.

Rapp CA, Moore TD. The first 18 months of mental health reform in Kansas. *Psychiatr-Serv.* 1995;46:580-5.

Rapp MS. A fatality possibly due to legal process. *CAN-J-PSYCHIATR.* 1986;31:486-487.

Reed A. Japan needs more forensic psychiatrists. *CRIM-BEHAV-MENT-HEALTH.* 1995;5:174-186.

Richardson ME. Rooming-in: An alternative to involuntary detention. *AUST-N-Z-J-PSYCHIATRY.* 1996;30:263-269.

Richert RA, Moyes AH. Reasons for involuntary commitment in Manitoba and Ontario. *CAN-J-PSYCHIATR.* 1983;28:358-361.

Riecher-Rossler A, Rossler W. Compulsory admission of psychiatric patients - an international comparison. *Acta Psychiatr Scand.* 1993;87:231-236.

Rochefort DA. Origins of the "Third psychiatric revolution": the Community Mental Health Centers Act of 1963. *J-Health-Polit-Policy-Law.* 1984;9:1-30.

Rochefort DA. The political context of mental health care. *New-Directions-for-Mental-Health-*

Services. 1987;Win No 36:93-105.

Rodgers JE. Psychosurgery: Damaging the brain to save the mind. 1992.

Romano J. Reminiscences: 1938 and since. *American Journal of Psychiatry.* 1990;147:785-92.

Romano J. Reminiscences: 1938 and since. *American Journal of Psychiatry.* 1994;151:83-89.

Rooney S, Murphy K, Mulvaney F, O'Callaghan E, Larkin C. A comparison of voluntary and involuntary patients admitted to hospital. *IR-J-PSYCHOL-MED.* 1996;13:132-137.

Rosenbaum M. Violence in psychiatric wards. Role of the lax milieu. *GEN-HOSP-PSYCHIATR.* 1991;13:115-21.

Rosenman S. Acute psychiatric beds: distribution and staffing in NSW and ACT. *Aust-N-Z-J-Psychiatry.* 1995;29:238-47.

Rosenthal TT. University psychiatric nursing education in the United States: 1917-1956. *Issues-in-Mental-Health-Nursing.* 1984;6:21-33.

Sanguineti VR, Samuel SE, Schwartz SL, Robeson MR. Retrospective study of 2.200 involuntary psychiatric admissions and readmissions. *American Journal of Psychiatry.* 1996;153:392-396.

Sharpe G. The Ontario Mental Health Act, 1978. A legal perspective. *CAN-J-PSYCHIATR.* 1979;24:517-519.

Sim LP, Lim LC, Lee SL, Lee CS. A study of police referrals to Woodbridge Hospital. *Singapore-Med-J.* 1990;31:131-4.

Singh S. Aspects of Mental Health Act 1990 in New South Wales Australia. *Med-Law.* 1996;15:441-6.

Smith A. Survey of locked facilities in Scottish psychiatric hospitals . *PSYCHIATR-BULL.* 1997;21:77-79.

Snow DL, Swift CF. Consultation and education in community mental health: A historical analysis. *Journal-of-Primary-Prevention.* 1985;6:3-30.

Snowdon J. Alternative proposals for reform of mental health legislation in Australia. *MED-J-AUST.* 1983;1:471-474.

Snowdon J. A review of compulsory admissions to a psychiatric unit in Sydney. *AUST-N-Z-J-PSYCHIATRY.* 1981;15:307-310.

Spengler A. Factors influencing assignment of patients to compulsory admission. *Social Psychiatry.* 1986;21:113-122.

Steadman HJ, Morrissey JP, Braff J, Monahan J. Psychiatric evaluations of police referrals in a general hospital emergency room. *INT-J-LAW-PSYCHIATRY.* 1986;8:39-47.

Stoddard FJ, Altman HG, Sheldon M, Senger H, Van Buskirk D. Psychiatric benefits and insurance regulation in Massachusetts: a national model? *American Journal of Psychiatry*. 1983;140:327-31.

Swidler RN, Tauriello JV. New York State's Community Mental Health Reinvestment Act. *PSYCHIATR-SERV*. 1995;46:496-500.

Talbott JA. Twentieth-century developments in American psychiatry. *Psychiatric-Quarterly*. 1982;54:207-219.

Toews J, El-Guebaly N, Leckie A, Harper D. Patients' attitudes at the time of their commitment. *CAN-J-PSYCHIATR*. 1984;29:590-595.

Torre E. Deinstitutionalization: Alternatives to mental hospitals in Italy. 1988.

Treffert DA. Legal "rites": Criminalizing the mentally ill. *Hillside-Journal-of-Clinical-Psychiatry*. 1981;3:123-137.

Tremblay PF, King PR, Baines GR. Clinical and demographic characteristics of voluntary and involuntary psychiatric inpatients. *CAN-J-PSYCHIATR*. 1994;39:297-299.

Turner TJ. Consent to psychiatric treatment in Ontario 1979. *PSYCHIATR-J-UNIV-OTTAWA*. 1980;5:82-85.

Tyrie CM. Mental Health Services in Germany. *PSYCHIATR-BULL*. 1992;16:40-42.

Verdun Jones SN. The dawn of a "new legalism" in Australia? The New South Wales Mental Health Act, 1983 and related legislation. *INT-J-LAW-PSYCHIATRY*. 1986;8:95-118.

Verma SK, Puri A. Law and clinical Law and clinical psychologists in India. *Indian-Journal-of-Clinical-Psychology*. 1996;23:79-86.

Vestergaard J. The Danish Mental Health Act of 1989: psychiatric discretion and the new legalism. *Int-J-Law-Psychiatry*. 1994;17:191-210.

Vestergaard J. The Danish Mental Health Act of 1938: "Progressive" psychiatric paternalism revised. *INT-J-LAW-PSYCHIATRY*. 1984;7:441-453.

Webb M. Republic of Ireland: White paper on a new mental health act: Response of the Irish Division of the Royal College of Psychiatrists. *PSYCHIATR-BULL*. 1997;21:307-311.

Werner JL, Tyler JM. Community-based interventions: A return to community mental health centers' origins. Special Issue: Consultation: A paradigm for helping: Consultation I: Conceptual, structural, and operational dimensions. *Journal-of-Counseling-and-Development*. 1993;71:689-692.

White D. A balancing act: Mental health policymaking in Quebec. *INT-J-LAW-PSYCHIATRY*. 1996;19:289-307.

Whiteford H. Mental Health Act reform [letter]. *N-Z-Med-J.* 1985;98:605.

Whyte B, Hunter S. Guardianship of the person in Scotland. *British-Journal-of-Social-Work.* 1992;22:167-186.

Yolles SF. Community psychiatry: 1963-74. *Journal-of-Operational-Psychiatry.* 1975;6:142-151.

Zealberg JJ, Christie SD, Puckett JA, McAlhany D, Durban M. A mobile crisis program: collaboration between emergency psychiatric services and police. *Hosp-Community-Psychiatry.* 1992;43:612-5.

Zifcak S. The United Nations Principles for the Protection of People with Mental Illness: Applications and limitations. *PSYCHIATR-PSYCHOL-LAW.* 1996;3:1-9.

Zimmermann Tansella C, Burti L, Faccincani C, Garzotto N, Siciliani O, Tansella M. Bringing into action the psychiatric reform in South-Verona. A five year experience. *Acta-Psychiatr-Scand-Suppl.* 1985;316:71-86.

F 3: Papers which referred to mental health issues but which made no specific reference to the MHA 1983 (n=87)

Mental health promotion in high risk groups. *Effective Healthcare.* 1997;3.

Acharyya S, Moorhouse S, Kareem J, Littlewood R. Nafsiyat: a psychotherapy centre for ethnic minorities. *PSYCHIATR BULL.* 1989;13:358-360.

Balarajan R, Raleigh VS. The ethnic populations of England and Wales: the 1991 Census. *Health Trends.* 1992;24:113-116.

Balarajan R, Raleigh VS, Yuen P. Hospital care among ethnic minorities in Britain. *Health Trends.* 1991;23:90-93.

Basson JV, Woodside M. Assessment of a secure intensive care-forensic ward. *Acta Psychiatr Scand.* 1981;64:132-41.

Bhugra D, Watson J. Suicide trends in the South-East Thames Region. *PSYCHIATR BULL.* 1989;13:366-367.

Bingley W. Broadmoor, Rampton and Ashworth: Can good practice prevent potential future disasters in high-security hospitals? *CRIM-BEHAV-MENT-HEALTH.* 1993;3:465-471.

Bingley W. Mental health act code of practice. *BR-MED-J.* 1990;300:1139.

Blom-cooper L, Murphy E. Mental Health services and resources. *PSYCHIATR-BULL.* 1991;15:65-68.

Boardman AP, Bouras N. The Mental Health Advice Centre in Lewisham. *Health Trends.* 1988;20:59-63.

Brooks PW. Codes of practice for the Mental Health Acts, England and Wales/Scotland. *PSYCHIATR-BULL.* 1991;15:311-312.

Bynoe I. Care and Security. *Nurs-Times.* 1992;88:39.

Campling P. Race, culture and psychotherapy. *PSYCHIATR BULL.* 1989;13:550-551.

Coid J. How many psychiatric patients in prison. *BR-J-PSYCHIATRY.* 1984;145:78-86.

Craddock N, Craddock B. Audit of psychiatric discharge summaries. *PSYCHIATR-BULL.* 1990;14:618-619.

Crammer JL. "English asylums and English doctors: Where Scull is wrong": Correction. *History-of-Psychiatry.* 1994;5:395.

Cumella SJ, Lawrence R, Robertson JA. A study of the accumulation of long-stay patients in a general hospital psychiatric department. *Health Trends.* 1988;20:48-51.

Donaldson C, Terrier N, Burns A. The impact of symptoms of dementia on caregivers. *BR J*

PSYCHIATRY. 1997;170:62-68.

Evans M. Using a psychoanalytical model to approach acts of self-harm. *Nursing Times.* 1994;90:38-40.

Faculty of Public Health Medicine. Housing or Homelessness: A public health perspective: A report from the working group on Housing and Health of the Committee on Health Promotion, the Faculty of Public Health Medicine of the Royal Colleges of Physicians of the United Kingdom. 1992.

Fleming DM, Crombie DL. Geographical variations in persons consulting rates in general practice in England and Wales. *Health Trends.* 1989;21:51-55.

Francis E, David J, Johnson N, Sashidharan SP. Black people and psychiatry in the UK. *PSYCHIATR BULL.* 1989;13:482-485.

Garden G, Oyebode F, Cumella S. Audit in psychiatry. *PSYCHIATR BULL.* 1989;13:278-281.

Glover GR. Medical audit and mental health care. *PSYCHIATR-BULL.* 1990;14:326-327.

Grant W. Sentence deferred - a useful psychiatric recommendation? *The Bulletin of the Royal College of Psychiatrists.* 1988;12:276-278.

Grazier KL. Institutions for Mental Diseases (IMDs): Facilities and clients. *Health Services Management Research.* 1992;5:148-158.

Green R. Measures of quality in mental health. *HOSP-HEALTH-SERV-REV.* 1987;83:215-219.

Gunn J. An English psychiatrist looks at dangerousness. *BULL-AM-ACAD-PSYCHIATR-LAW.* 1982;10:143-153.

Hambridge JA. The grief process in those admitted to Regional Secure Units following homicide. *Journal-of-Forensic-Sciences.* 1990;35:1149-1154.

Hamilton JR. Code of practice for the Mental Health Act 1983. "Patronising and unrealistic" [editorial]. *Br-Med-J-Clin-Res-Ed.* 1986;292:1219-20.

Hamilton JR. Insanity legislation. *J-Med-Ethics.* 1986;12:13-7.

Hannigan B, Bartlett H, Clilverd A. Improving health and social functioning: Perspectives of mental health service users. *Journal of Mental Health.* 1997;6:613-619.

Harper RJ III. The future of CMHCs: The role of the state. *ADM-POLICY-MENT-HEALTH.* 1994;21:319-324.

Harrison G, Owens D, Holton A. A prospective study of severe mental disorder in Afro-Caribbean patients. *PSYCHOL-MED.* 1988;18:643-657.

Haslam MT. Human rights: the right to receive treatment and care. *Med-Law.* 1993;12:291-5.

Hawton K. Assessment of suicide risk. *BR-J-PSYCHIATRY.* 1987;150:145-153.

Hirsch S, Spence S. Ethical approaches to researching the mentally incapable patient. *PSYCHIATR-BULL.* 1995;19:414-416.

Hocking J. Don't ask me I'm only the client. *Social Work Today.* 1992;23:13.

Hodes M, Creamer J, Woolley J. Cultural meanings of ethnic categories. *PSYCHIATR-BULL.* 1998;22:20-24.

Holman C. Medical Audit in psychiatry, or Fear and loathing on the White Paper trail. *PSYCHIATR BULL.* 1989;13:281-284.

James DH. The Mental Health Acts and people with severe learning disability. *PSYCHIATR-BULL.* 1993;17:357-358.

Johnstone EC, Crow TJ, Johnson AL, Macmillan JF. The Northwick Park Study of first episodes of schizophrenia - presentation of the illness and problems relating to admission. *BR J PSYCHIATRY.* 1986;148:115-119.

Kennedy B. The development of a Mental Health Service within central Nottinghamshire Health Authority. *HOSP-HEALTH-SERV-REV.* 1988;84:9-12.

Kirkpatrick A, Feldman P. Is anyone out there listening? Official enquiries into psychiatric hospitals - part 2. *HOSP-HEALTH-SERV-REV* . 1983;79:69-76.

Larkin EP, Collins PJ. Fitness to plead and psychiatric reports. *MED-SCI-LAW.* 1989;29:26-32.

Lillington B. Mental Health Act Commission. Credibility and resource. *PSYCHIATR BULL.* 1989;13:585-586.

Lim MH. A psychiatric emergency clinic: A study of attendances over six months. *BR-J-PSYCHIATRY.* 1983;143:460-466.

Littlewood R. Ethnic minorities and the Mental Health Act: patterns of explanation. *The Bulletin of the Royal College of Psychiatrists.* 1986;10:306-308.

Littlewood R, Lipsedge M. Psychiatric illness among British Afro-Caribbeans. *BR-MED-J.* 1988;296:950-951.

Loane R, Jefferys P. Consultation-liaison in an old age psychiatry service. *PSYCHIATR-BULL.* 1998;22:217-220.

London M. Mental Illness among immigrant minorities in the United Kingdom. *BR-J-PSYCHIATRY.* 1986;149:265-273.

Lovett L. The life of a group on a locked ward. *PSYCHIATR BULL.* 1989;13:60-62.

Lyall R. Legal Aspects. 1991.

Manger D, Oppenheimer C. Areas of doubt. *Social Work Today.* 1989;21:23.

Maxwell J, Egan V, Chiswick A, et al. HIV-1 associated cognitive/motor complex in an injecting drug user. *AIDS-CARE.* 1991;3:373-381.

McClintock TL. Sexual offending. *INT-REV-PSYCHIATRY.* 1995;7:253-259.

McGregor C. Crossing a mental health border. *Social Work Today.* 1985;16:16-17.

Mendelson EF, Hurley A, Williams T. Trainee's attitudes to forensic psychiatry, the courts, and attending conferences. *PSYCHIATR-BULL.* 1990;14:77-79.

Moodley P, Perkins RE. Blacks and psychiatry: a framework for understanding access to psychiatric services. *PSYCHIATR-BULL.* 1990;14:538-539.

Morgan J. Autonomy and safeguards in people with impaired decision-making abilities. *PSYCHIATR-BULL.* 1990;14:603-607.

Murphy E. The future of Britain's high security hospitals. *BMJ.* 1997;314:1292-3.

Murphy E. Inspecting the NHS. *BR-MED-J.* 1990;301:241.

Nazroo JY. Ethnicity and Mental Health. Findings from a national community survey. *POLICY STUDIES INSTITUTE.* 1997.

Needham-Bennett H, Parrott J, Macdonald AJD. Psychiatric disorder and policing the elderly offender. *CRIM-BEHAV-MENT-HEALTH.* 1996;6:241-252.

Nicol A, Sheppard J. Why keep hospital clinical records? *BR-MED-J.* 1985;290:263-264.

North CS, Smith EM. A systematic study of mental health services utilization by homeless men and women. *Soc. Psychiatry Psychiatr Epidemiol.* 1993;28:77-83.

O'Kane A, Fawcett D, Blackburn R. Psychopathy and moral reasoning: Comparison of two classifications. *Personality-and-Individual-Differences.* 1996;20:505-514.

Pai M, White AC, Deane AG. Lithium augmentation in the treatment of delusional depression. *BR-J-PSYCHIATRY.* 1986;148:736-738.

Parkman S, Davies S, Leese M, Phelan M, Thornicroft G. Ethnic differences in satisfaction with mental health services among representative people with psychosis in South London: PRiSM Study 4. *British Journal of Psychiatry.* 1997;171:260-264.

Paton C, Wolfson P. Haematological monitoring for clozapine: Do patients know why? *PSYCHIATR-BULL.* 1995;19:536-537.

Potter J. Mentally disordered homeless offenders - diversion from custody. *Health Trends.* 1990;22:51-53.

Priest RG. Consent to Treatment: Mental Health Act Commission. *The Bulletin of the Royal*

College of Psychiatrists. 1985;9:230.

Raleigh VS. Suicide patterns and trends in people of India Subcontinent and Carribean origin in England and Wales. *Ethnicity and Health.* 1996;1:55-64.

Ramsay R. Research and practices in Forensic Psychiatry. Conference reports. *PSYCHIATR BULL.* 1989;13:373-374.

Renvoize E, Clayden D. Can the suicide rate be used as a performance indicator in mental illness? *Health Trends.* 1990;22:16-20.

Singh TH. Mental Health Act 1983: guardianship order and definition of mental impairment [letter]. *BR-MED-J.* 1989;299:1284.

Snaith RP, Price DJ, Wright JF. Psychiatrists' attitudes to psychosurgery: Proposals for the organization of a psychosurgical service in Yorkshire. *BR-J-PSYCHIATRY.* 1984;144:293-297.

Teplin LA, Swartz J. Screening for severe mental disorder in jails. *Law and Human Behaviour.* 1989;13:1-18.

Tombs D, Bennett C. The evaluation of the Worcester Development Project. Conference on Developments in Mental Health Care in the European Community (1985, London, England). *Int-J-Soc-Psychiatry.* 1987;33:92-98.

Vartiainen H, Hakola P. Monitored conditional release of persons found not guilty by reason of insanity. *American Journal of Psychiatry.* 1992;149:415.

Wade B. Older people, prescribed drug consumption and the general practitioner contract. *Health and Social Care in the Community.* 1995;3:241-247.

Watson JP, Jolley DJ. A survey into the availability of higher specialist training in the psychiatry of old age in England and Wales 1983-88 and the yield of consultants from the training scheme. *PSYCHIATR BULL.* 1989;13:514-524.

Wells JS. Discontent without focus? An analysis of nurse management and activity on a psychiatric in-patient facility using a 'soft systems' approach. *J-Adv-Nurs.* 1995;21:214-21.

Whyte A. The Long route to hospital. *Community Care.* 1989;782:23-25.

Woo SM, Goldstein MJ, Nuechterlein KH. Relative's expressed emotion and non-verbal signs of subclinical psychopathology in schizophrenic patients. *BR J PSYCHIATRY.* 1997;170:58-61.

Woods P. How nurses make assessments of patient dangerousness. *Mental Health Nursing.* 1996;16:20-22.

Worrall EP. Consent to treatment and clinical decision analysis. *PSYCHIATR BULL.* 1989;13:79-81.

F 4: Papers detailing results and comments from studies relating to the 1959 MHA (n=18)

Bolton P. Management of compulsorily admitted patients to a high security unit. *Int-J-Soc-Psychiatry.* 1984;30:77-84.

Dawe AM. A case for community psychiatric nurses. *J-ADV-NURS.* 1980;5:485-490.

Dean G, Walsh D, Downing H, et al. First admission of native-born and immigrants to psychiatric hospitals in South East England 1976. *BR-J-PSYCHIATRY.* 1981:506-512.

Grounds AT. The transfer of sentenced prisoners to hospital 1960-1983: A study in one special hospital. *British-Journal-of-Criminology.* 1991;31:54-71.

Harrison G, Ineichen B, Smith J. Psychiatric hospital admissions in Bristol. Social and clinical aspects of compulsory admission. *BR-J-PSYCHIATRY.* 1984;145:605-611.

Hitch PJ, Clegg P. Modes of referral of overseas immigrant and native-born first admissions. *SOC-SCI-MED.* 1980;14A:369-374.

Howard RC, Fenton GW, Fenwick PB. The contingent negative variation, personality and antisocial behaviour. *Br-J-Psychiatry.* 1984;144:463-74.

Howard R, Lumsden J. A neurophysiological predictor of reoffending in special hospital patients. *CRIM-BEHAV-MENT-HEALTH.* 1996;6:147-156.

Ineichen B, Harrison G, Morgan HG. Psychiatric hospital admissions in Bristol I. Geographical and ethnic factors. *BR-J-PSYCHIATRY.* 1984;145:600-604.

MacKay RD, Wight RE. Schizophrenia and anti-social (criminal) behaviour - some responses from sufferers and relatives. *MED-SCI-LAW.* 1984;24:192-198.

MacMillan JF, Johnson AL. Contact with the police in early schizophrenia: It's nature, frequency and relevancy to outcome of treatment. *MED-SCI-LAW.* 1987;27:191-200.

McGovern D, Cope R. The compulsory detention of males of different ethnic groups, with special reference to offender patients. *BR-J-PSYCHIATRY.* 1987;150:505-512.

McGovern D, Cope R. First psychiatric admission rates of first and second generation Afro-Caribbeans. *Social Psychiatry.* 1987;22:139-149.

Robertson G, Gibbens TCN. Transfers from prisons to local psychiatric hospitals under section 72 of the 1959 Mental Health Act. *BR-MED-J.* 1980;280:1263-1266.

Shubsachs APW, Huws RW, Close AA, Larkin EP, Falvey J. Male Afro-Caribbean patients admitted to Rampton Hospital between 1977 and 1986 - A control study. *MED-SCI-LAW.* 1995;35:336-346.

Szmukler GI, Bird AS, Button EJ. Compulsory admissions in a London borough: I. Social and

clinical features and a follow-up. *PSYCHOL-MED.* 1981;11:617-636.

Teplin LA. The criminality of the mentally ill: speculation in search of data. *Psychological Bulletin.* 1983;94:54-67.

Teplin LA. Criminalizing mental disorders: The comparative arrest rate of the mentally ill. *American Psychologist.* 1984;39:794-803.

F 5: Papers which referred to Mental Health Review Tribunals (n=11)

Reform of the mental health law - 2(notes for students). *HOSP-HEALTH-SERV-REV*. 1984;80:50-52.

Davison P, de Albeniz AP. Reports prepared for Mental Health Review Tribunals and Managers' Reviews. *PSYCHIATR-BULL*. 1997;21:364-366.

Grounds AT. A new appraisal of Mental Health Review Tribunals. *PSYCHIATR BULL*. 1989;13:299-300.

Hepworth D. The decision process of the mental health review tribunal. I. Review of literature and research. *MED-SCI-LAW*. 1983;23:131-141.

Kaplan CA. Mental Health Review Tribunals and the Council on Tribunals. *PSYCHIATR-BULL*. 1995;19:438-441.

Mawson DS. The function of mental health review tribunals under the Mental Health Act 1983. *MED-SCI-LAW*. 1986;26:291-294.

Myers DH. Mental health review tribunals. A follow-up of reviewed patients. *BR-J-PSYCHIATRY*. 1997;170:253-256.

Prins H. The Mental Health Review Tribunal and the restricted patient. *PSYCHIATR-BULL*. 1997;21:102-104.

Saad KFG, Sashidharan S. Mental Health Review Tribunals. *PSYCHIATR-BULL*. 1992;16:470-472.

Shah M, Oyebode F. The use of mental health review tribunals. *PSYCHIATR-BULL*. 1996;20:653-655.

Wood J. Reform of the Mental Health Act 1983: An effective tribunal system. *BR-J-PSYCHIATRY*. 1993;162:14-22.

F 6: Papers which debated 'consent to treatment' issues (n=40)

Mentally disabled offenders. *Mental-and-Physical-Disability-Law-Reporter.* 1984;8:527.

Benbow SM, Jones R. Mental incapacity: implications of The Law Commission Report. *PSYCHIATR-BULL.* 1996;20:645-647.

Bingley W. Assessing dangerousness: protecting the interests of patients. *Br-J-Psychiatry-Suppl.* 1997:28-9.

Bingley W. Surgical castration for sex offenders. No role for Mental Health Act Commission [letter; comment]. *BR-MED-J.* 1993;307:1141.

Bingley W. "Treatment: Use, abuse and consent": Discussion. Conference of the University of London, Institute of Psychiatry (1990, London, England). *CRIM-BEHAV-MENT-HEALTH.* 1991;1:138-141.

Black W. Resource implications of Munchausen's syndrome. *BR-J-PSYCHIATRY.* 1993;162:847-848.

Butler J, Vostanis P. Characteristics of referrals to a mental health service for young people in care. *PSYCHIATR-BULL.* 1998;22:85-87.

Commander M, Odell S. Admission of the homeless mentally ill in the UK. *PSYCHIATR-BULL.* 1998;22:207-210.

Commander M, Odell S, Sashidharan S. Birmingham community mental health team for the homeless. *PSYCHIATR-BULL.* 1997;21:74-76.

Craig T. Homelessness and mental health. *PSYCHIATR-BULL.* 1998;22:195-197.

Crawford MJ, Kohen D. Urgent psychiatric assessment in an inner-city A&E department. *PSYCHIATR-BULL.* 1997;21:625-626.

Department of Health and Social Security. Offenders suffering from psychopathic disorder. *Health Notice.* 1986;HN (86) 28.

Department of Health Press Office. Dorrell to scrap mental health act managers' powers to discharge detained patients. 1996;H96/296.

Draper RJ, Dawson D. Competence to consent to treatment: A guide for the psychiatrist. *CAN-J-PSYCHIATR.* 1990;35:285-289.

Dyer AR, Bloch S. Informed consent and the psychiatric patient. *J-Med-Ethics.* 1987;13:12-6.

Dyer C. First negligence action against Mental Health Act Commission. *BR-MED-J.* 1990;301:1296-1297.

Eastman N. Surgical castration for sex offenders. *BR-MED-J.* 1993;307:1141.

Elton A, Honig P, Bentovim A, Simons J. Withholding consent to lifesaving treatment: Three cases. *BR-MED-J.* 1995;310:373-377.

Fennell P. Informal compulsion: The psychiatric treatment of Juveniles under common law. *Journal of Social Welfare and Family Law.* 1992;4:311-333.

Hardie T, Bhui K, Brown P. The emergency treatment of overdose: A problem of consent to treatment. *PSYCHIATR-BULL.* 1995;19:7-9.

Helme T. The Voluntary Euthanasia (Legalization) Bill (1936) revisited. *J-Med-Ethics.* 1991;17:25-9.

Hughes T, Hampshaw S, Renvoize E, Storer D. General hospital services for those who carry out deliberate self-harm. *PSYCHIATR-BULL.* 1998;22:88-91.

Independent. £27,500 damages for woman committed to mental hospital. *The Independent Newspaper.* 1989;3rd May.

Jervis Me. Cause for concern. *Social Work Today.* 1990;21:23-25.

Jones RG. Ethical and legal issues in the care of demented people. *Reviews-in-Clinical-Gerontology.* 1993;3:55-68.

Kanjilal GC. Consent and the mentally handicapped. *PSYCHIATR BULL.* 1989;13:82-83.

Kingdon D. Mental Heallth services: results of a survey of English district plans. *PSYCHIATR BULL.* 1989;13:77-78.

Law Report. Enforced caesareans. *Bulletin of Medical Ethics.* 1997;April:20-24.

Marriott SVL, Harvey RH, Bonner D. Health in hostels: a survey of hostel dwelling women. *PSYCHIATR-BULL.* 1997;21:618-621.

McGhee MF. Compulsory admission to hospital of an alcoholic patient under the mental health act [letter] [see comments]. *J-R-Coll-Gen-Pract.* 1989;39:301.

McNulty C. Mentally incapacitated adults and decision-making: a psychological perspective. Comments on Law Commission consultation papers, numbers 128, 129 and 130. *Med-Sci-Law.* 1995;35:159-64.

Murray I. Mental patients being held in hospital illegally. *The Times Newspaper.* 1997;3rd December.

Nicholls KR. Holding powers in an A&E department. *PSYCHIATR-BULL.* 1997;21:615-617.

Pariente D. Diplomatic immunity and the Mental Health Act 1983. *PSYCHIATR-BULL.* 1991;15:207-209.

Peck E. Working for psychiatric patients? Mental health services and the White Paper. *PSYCHIATR BULL.* 1989;13:407-408.

Porter S, Williams C. Psychiatric dilemmas--surgery and the Mental Health Act (1983). *J-R-Soc-Med.* 1997;90:327-30.

The College. Consent to psychiatric treatment for informal patients: College advice to Psychiatrists. *The Bulletin of the Royal College of Psychiatrists.* 1985;9:228-229.

Thomas CJ. Mental Health Act and medical treatment without consent [letter]. *Br-J-Psychiatry.* 1986;148:340.

Thompson A. Last word. *Community Care.* 1995;1087:14-15.

Wolfson P, Cohen M, Lindesay J, Murphy E. Section 47 and its use with mentally disordered people. *J-PUBLIC-HEALTH-MED.* 1990;12:9-14.

F 7: Papers which provided data and commentary regarding 'guardianship' or 'supervised discharge' (n=11)

Coffey M. Supervised Discharge: concerns about the new powers for nurses. *Br-J-Nurs.* 1997;6:215-218.

Craig A. Guardianship Survey. *Social Services Research.* 1988;4:39-42.

Davies S, Bruce J, Fallows S. Section 25 - after-care under supervision : the first eighteen months experience. *in Press: Medicine, Science and the Law.* 1998.

Dooher I. Research note: Guardianship under the Mental Health Act 1983: Practice in Leicestershire. *British-Journal-of-Social-Work.* 1989;19:129-135.

Exworthy T. Compulsory care in the community: A review of the proposals for compulsory supervision and treatment of the mentally ill in the community. *CRIM-BEHAV-MENT-HEALTH.* 1995;5:218-241.

Fennell P. Falling through the legal loopholes. *Social Work Today.* 1989;21:18-20.

Grant W. Guardianship orders: A review of their use under the 1983 Mental Health Act. *MED-SCI-LAW.* 1992;32:319-324.

Hughes G. Trends in guardianship usage following the Mental Health Act 1983. *Health Trends.* 1990;22:145-147.

Wattis JP, Grant W, Traynor J, Harris S. Use of guardianship under the 1983 Mental Health Act. *MED-SCI-LAW.* 1990;30:313-316.

Whiteley P. Mental Health reforms likely. *Community Care.* 1995;1096:9.

Whitworth H, Singhal S. The use of guardianship in mental handicap services. *PSYCHIATR-BULL.* 1995;19:725-727.

F 8: Papers which referred to the Mental Health (Patients in the Community) Act 1995. (n=10)

Anstee BH. An alternative form of community care for the mentally ill: supported lodging schemes...a personal view. *Health Trends.* 1985;17:39-40.

Beese J, Turnbull J. Time to act--community mental health. *Nurs-Manag-Harrow.* 1996;3:20-1.

Bowl R. Involving service users in mental health services: Social Services Departments and the NHS Community Care Act 1990. *Journal of Mental Health.* 1996;5:287-303.

Dyer JAT. Treatment in the commmunity in the absence of consent. *PSYCHIATR-BULL.* 1998;22:73-76.

Eastley R, Nowers M. A community mental health team for the elderly: a survey of GPs' views on the service. *PSYCHIATR-BULL.* 1997;21:89-90.

Eastman N. Anti-therapeutic community mental health law. *BMJ.* 1995;310:1081-1082.

Ford J, Rigby P. Aftercare under supervision: implications for CMHNs. *Br-J-Nurs.* 1996;5:1312-6.

Griffiths D. When care is pushed to the limit. *New Statesman and Society.* 1993;6:12-13.

Haw C, Lanceley C, Vickers S. Patients at a psychiatric walk-in clinic - who, how, why and when? *Bulletin of the Royal College of Psychiatrists.* 1987;11:329-332.

Silcock S, Halpern A. Not just a quick fix. *Community Care.* 1993;965:22.

F 9: Papers which referred to the Care Programme Approach (n=3)

Grace J, Steels M, Baruah R. General practitioners knowledge of and views on the care programme approach. *PSYCHIATR BULL*. 1996;20:643-644.

Jamieson JS. The care programme approach: A descriptive study of its use among discharges from the Southsea acute psychiatric unit. *PSYCHIATR BULL*. 1996;20:550-552.

Lelliot P. Should psychiatrists support CPA, guidelines and routine outcome measurement? *PSYCHIATR BULL*. 1997;21:1-2.

F 10: Papers which referred to other parts of the Mental Health Act 1983. (n=12)

Bluglass R, Beedie MA. Mental Health Act 1983 [letter]. *Br-Med-J-Clin-Res-Ed.* 1983;287:359-60.

Dimond B. Staff protection against civil and criminal action under the Mental Health Act 1983. *The Bulletin of the Royal College of Psychiatrists.* 1987;11:333-337.

Hall AD, Puri BK, Meehan K, Read JH. An investigation into the practice and benefits of statutory aftercare in an inner city psychiatric service. *Int-J-Clin-Pract.* 1997;51:355-8.

Jefferys PM. Misunderstandings on Consent to Treatment in the Mental Health Act 1983. *The Bulletin of the Royal College of Psychiatrists.* 1984;8:136.

Keywood K. Rectification of incorrect documentation under the Mental Health Act 1983. *J-FORENSIC-PSYCHIATRY.* 1996;7:79-91.

Langley GE. The Mental Health Act 1983 - second opinions under Section 58: treatment with electroplexy or extended medication. *The Bulletin of the Royal College of Psychiatrists.* 1985;9:92-94.

Murphy E. The compulsory removal of elderly people in England and Wales under Section 47. *Age and Ageing.* 1995;24:543.

Oyebode F. Ethics and Section 58 of the Mental Health Act. *PSYCHIATR-BULL.* 1993;17:481-483.

The college. Approval of medical practitioners under Section 12 of the Mental Health Act 1983. *The Bulletin of the Royal College of Psychiatrists.* 1984;8:183.

West ED. Second opinions for ECT and extended medication - Mental Health Act 1983: Attitudes of consultant psychiatrists and analysis of 200 second opinion visits. *The Bulletin of the Royal College of Psychiatrists.* 1987;11:300-302.

Wilkinson E, Richards H. Aftercare under the 1983 mental health act. *PSYCHIATR-BULL.* 1995;19:158-160.

Williams T. Not just a rubber stamp. *Community Care.* 1988;693:22-23.

F 11: Papers which provided guidance on the use of the Act. (n=18)

Reform of the mental health law (notes for students). *HOSP-HEALTH-SERV-REV.* 1983;79:241-243.

Azuonye IO. What to write on Mental Health Act form 38 [2]. *PSYCHIATR-BULL.* 1997;21:304.

Curran C, Bingley W, Rodgers E. Approved Social Workers: Safety and professional support. *MED-SCI-LAW.* 1995;35:261-268.

Curran C, Rodgers E. Detention of inpatients under Section 5 of the Mental Health Act 1983. *Health Care Risk Report.* 1996;2:8-10.

Department of Health. Mental Health (Hospital, Guardianship and Consent to treatment) ammendment Regulations 1997. 1997;EL(97)26.

Department of Health. The use of "trial leave" under Section 17 of the Mental Health Act 1983 to transfer patients between hospitals. *Health Service Guidelines.* 1996;HSG(96)28.

Department of Health and Social Security. Mental Health Act 1983 implementation of sections 35, 36, 38 and 40(3). *Health Circular.* 1984;HC(84)24.

Department of Health and Social Security. Mental Health Act 1983 implementation of sections 35, 36 and 38. *Health Notice.* 1984;HN (84) 7.

Dimond B. Mental health law and the occupational therapist. *British-Journal-of-Occupational-Therapy.* 1988;51:307-311.

Finch JD. Perceptions and misperceptions of Mental Health Law (Notes for students). *HOSP-HEALTH-SERV-REV.* 1988;84:41-44.

George M. Mental Health Act 1983. *Community Care.* 1993;984:20.

James DV, Hamilton LW. Setting up psychiatric liaison schemes to magistrates' courts: problems and practicalities. *Med-Sci-Law.* 1992;32:167-76.

Killen S. Mental health nursing: nurses and the Mental Health Act. *Nurs-Times.* 1983;79:44-5.

Moore P. Organising Section under the Mental Health Act. *PULSE.* 1991;51:60.

Parkin A. Mental health act 1983: Legal responsibility of managers. *HOSP-HEALTH-SERV-REV.* 1987;83:157-161.

Smith D. A confused nurse's guide to the Mental Health Act. *Nurs-Mirror.* 1984;158:25-31.

The College. The seclusion of psychiatric patients. Public Policy Committee. (correspondence). *PSYCHIATR-BULL.* 1990;14:754-756.

Williamson C. Patient's appeals against compulsory detention: A systematic procedure for applying the Mental Health Act 1983. *HOSP-HEALTH-SERV-REV.* 1984;80:179-181.

F 12: Untranslated foreign papers (n=4).

[Establishment of patient's rights--a memo by the Mental Health Section, Public Health Conference at revision of the Mental Health Act]. *Kango-Gijutsu*. 1987;33:346-8.

Dabrowski S. Paternalistic personalism in Polish psychiatry. *Psychiatria-Polska.* 1994;28:17-21.

Gwynne Lloyd M, Benezech M. The Mental Health Act Commission for England and Wales. *J-MED-LEG-DROIT-MED.* 1995;38:415-428.

Gwynne Lloyd M, Benezech M. Supervised discharge of difficult mentally disordered patients in English law. *J-MED-LEG-DROIT-MED.* 1997;40:3-8.