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A CRITICAL REVIEW OF PATIENTS UNDER SECTION 5(2) OF THE MENTAL HEALTH ACT OF 1983

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SUMMARY

Background: *Patients who suffer from mental illness within the definition of the Mental health Act of 1983 and present a risk to themselves, to other people or at risk of self neglect or deterioration can be detained under section. Section 5(2), applies for patients who are already admitted to hospital and express their wish to leave against medical advice. It requires the recommendation of one medical practitioner. It gives the power to detain them for 72 hours in hospital for further assessment.*

To safeguard malpractice of this section Trusts have developed policies and procedures which defines good medical practice within the legal framework of the MHA 1983.

Aims: *To evaluate current medical practice and insure that it complies with trust's policies and procedures and applies good medical practice.*

Methods: *Medical Case notes of patients admitted from 1.1.07-30.6.07 and were detained under section 5(2) were reviewed. A special form was devised to collect information from the notes. It included age, sex, marital status, occupation, diagnosis, history or violence, history of drug and alcohol abuse and circumstances of their detention were obtained.*

Results: *44 patients were identified. 40% were men, 65% above the age of 50 years, 52% were sectioned after hours or at the weekends. Measures to persuade patients to stay as an informal patient were taken in 16%. 55% were sectioned by the on call doctor. 68.5% exhibited threatening behaviour. 30% had self neglect, 13% were a risk to others, 26% had a deliberate self harm risk. 60% had moderate to severe suicidal risk and ideation. 68% did not have mental health capacity to give consent for admission. 60% had been assessed in the first 24 hours of their section. 60% were converted to section 2,3 of the Mental Health Act. 25% stayed as informal patients and 7% were discharged.*

Discussion: *Female patients were more likely to be put on section 5(2) which was against expectation. Older people were more likely to be put on section 5(2) which was again against expectation. Majority of patients were a risk to themselves and only 13% were a risk to other people. Nearly two third were assessed within 24hrs from the section which was something we commend our services on. 60% needed to be transferred to different sections which indicates that 40% of the sample could have been managed more efficiently without warranting section 5(2).*

Conclusion: *Section 5(2) is a useful legal framework when it is used efficiently. This study has shown that current clinical practice could be improved by applying the least restrictive measures by giving the patient more choice and empowering them in clinical decision making.*

Key words: *Section 5(2) - mental health act*

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INTRODUCTION

The Mental Health Act of 1983 (MHA) is an Act of the Parliament of the United Kingdom but applies only to people in England and Wales. It stipulates compulsory admission for assessment and, management of people who suffer from mental illness in hospital. It specifies criteria to establish that patients suffers from identifiable mental illness within the definition of the Act and pose a risk to themselves or to other people or there is a risk of self neglect or deterioration if untreated can be detained in hospital under the MHA (Code of Practice 2008).

There are sections for mentally ill offenders and sections which are for compulsory treatment of mentally ill patients. Compulsory treatment sections are section 2 which is for 28 days assessment and treatment, section 3 which is for six months for treatment. Section 4 for emergency treatment for 72 hours for patients in the community and section 5(2) which is our study's subject.

Section 5(2) of the MHA, is a doctor's holding power for seventy two hours in hospital. It can only be applied on patients who are already informally admitted to hospital, but who then change their mind and wish to leave. It can be implemented following an assessment by the responsible clinician (RC) or his deputy, which, in effect, is any hospital doctor who is treating the patient, including psychiatrists. It lasts up to 72 hours, during which time a further assessment may result in either discharge from the Section or detention under Section 2 or Section 3 of the MHA.

METHODS

Medical Case notes of patients admitted informally from 30.6.05 to 31.12.2005 and were detained later under section 5(2) were reviewed. A special form was devised to collect information from the notes. It included age, sex, marital status, occupation, diagnosis, history of violence, history of drug and alcohol abuse and circumstances of their detention, in addition to the ward the patient was on. It concentrated in details about the admission which preceded the section, the risk the patient presented to him/herself, to others and the risk of

self neglect. What time of the day the section was implemented, time lapsed until further assessment was done and the outcome of that assessment also focused on time since informal admission, measures that were taken to persuade the patient to stay in order to, the use of the least restrictive measures, whether there was clear evidence that they wanted to leave the ward, which doctor recommended the section, total time taken to conclude the section, was the patient transferred to another ward and what was the outcome of that section.

Table 1. Shows demographic characteristics of Patients on Section 5(2)

	No.	%
Sex		
Female	26	59
Male	18	41
Age Range		
21-40 Years	8	18
40-70 years	36	82
Psychiatric Wards		
Assessment Unit	15	34
Acute Psychiatric Wards	21	48
Elderly and Rehabilitation Wards	10	23
Which Doctor Recommended the Section		
On Call Doctor	24	55
Team Doctor	8	18
Not Documented	12	27

RESULTS

44 patients were identified, 26 (59%) were women and 18 (41%) men, 8 (18%) were less than 40 years old and 36 (82%) were above 40 years as demonstrated in (Table 1). 15(34%) were admitted to the assessment unit which was a ward created to admit people for assessment for 72 hours to decide whether they need a longer admission or whether their crisis can be managed in that time. 19 (43%) were admitted to our acute psychiatric wards and 10 (23%) were on the rehabilitation wards and on the elderly wards. There were 39 (88%) patients who had documentary evidence of informal admission and 5 (11%) were lacking such evidence as shown in (Table 2). There were 24 (54%) without documentation about how long they had been an informal patient before the section was implemented. In 17 (39%) it was done in the first 10 days of admission, while only 3 (7%) after 15 days of admission. 23 (52%) were done after hours 24 (55%) were recommended by the on call doctor, 8 (18%) by the team doctor and 12 (27%) not documented. In 37 (84%) of the sample there was no evidence of measures taken to persuade patients to stay as an informal patient while only 7 (16%) had such evidence. In 26 (59%) there was a risk of self harm, 13 (30%) risk to others and 30 (68%) risk of self neglect. In thirty there was (68%) evidence of patients threatened to leave the ward and 30 (68) lacked capacity to give valid consent regarding staying on the ward. 23 (52%) lacked documents about the time lapsed between the recommendation and the implementation of the section, while in 10 (23%) it was implemented immediately and in 11 (25%) it was implemented after its delivery to the hospital manager. In 23 (52%) the assessment was concluded in less than 24 hours, 6 (14%) in less than 48 hours, in 9 (20%) in less than 72 hours and in 4 (9%) the 72 hours lapsed without review and in 2 (5%) there was no documentation. There were 3 (7%) who were transferred to another ward while on section. 30 (68%) were upgraded to section 2 and 3. 11 ((25%0 continued as informal patients and 1 (2%) was discharged as shown in (Table 3).

Table 2. Demonstrates Time Scale and Risks considered for Section 5(2)

	No.	%
Documentary Evidence of Informal Admissions		
There is evidence	30	68
No Evidence	14	32
Time lapsed since informal admission		
Less than 3 days	14	32
Lessthan 10 days	3	7
15 days and more	3	7
No documented	24	55
Measures to persuade Patient to stay Informal		
There is documents	7	16
No documents	37	84
Time lapsed between recommendation and implantation		
Immediately	10	23
After Delivery to Hospital Manager	11	25
No Documents	23	52
Reasons for Detention		
Deliberate self harm	26	59
Risk to others	13	30
Risk of Self Neglect	30	68

Table 3. Shows the Outcome of Section 5(2)

	No.	%
Documentary Evidence of Threatening to Leave		
Yes	30	68
Not documented	14	32
Capacity to Give Consent		
Poor	30	68
Not documented	14	32
Total time to conclude assessment		
Less than 24 Hours	23	52
Less than 48 Hours	6	14
Less than 72 Hours	11	25
Lapsed without review	4	9
Was Patient transferred to another ward		
Yes	3	7
No	41	93
What was The Outcome		
Section 2,3	30	68
Stayed Informal	11	25
Discharged	1	2

DISCUSSION

Patients who are admitted to hospital usually suffer from serious illness and severe enough to warrant admission to hospital. Patients who are assessed under section 5(2) are patients who are already admitted to hospital and they want to leave. There is a professional concern about them presenting a risk to themselves or to others or there is a risk of self neglect, for that reason, they should be taken seriously, their assessment should be carried out thoroughly and their documentations should be done very clearly and accurately. There is an element of coercion, and they are more often dissatisfied with the service and more prone to complain (Ruggeri 1994, Leimkühler & Müller 1996, Williams & Wilkinson 1995). Having said that, some patients and their carers were satisfied with the section in some studies (Crawford et al. 2004). Unfortunately, this study has not demonstrated that, at least, the documentation was not done properly as in 27% of them no record about who sectioned them, 32% no documentary evidence about their informal admission, 55% no records how long did they stay in hospital before considering the section, 52% no records of how long did they stay in hospital before they were put on section 5(2), 84% was no evidence whether there was a measure to persuade them to stay as an informal patients before the section was considered, in 32% there was no evidence of mental capacity assessment and in 9% they were not assessed before the 72 hours section period had lapsed which really alarming.

Age and sex was against expectation as 82% of the sample were above 40 years old and females were more than males. Acute wards composed nearly 50% of the sample which is within expectations. On call doctors assessed 55% of the sample as expected as patients want to leave after hours. 59% of patients presented a risk to themselves while 68% presented risk of self harm which indicate an attitude focused on the patients and their wellbeing rather than a risk averse practice. 7% were transferred to a different war while on section 5(2) which should not have happened and the section should have been assessed and concluded before the transfer of patients.

Nearly two thirds were assessed within 24hrs from the section which was something we commend our services on. 60% needed to be transferred to different sections which indicate that 40% of the sample could have been managed more efficiently, in a way which had not warranted the use of section 5(2).

Circumstances which have led to assessment under section 5(2) were risk of absconding, physical or verbal aggression to staff or patients, agitation, noncompliance with medication.

Assessing and Managing risk of people with mental illness is a very important responsibility of psychiatry, otherwise much blame and criticism will be levelled at the profession by the community (Mullen 2005).

CONCLUSION

Patients who are assessed under section 5(2) are posing difficulties in their management, progress or response to treatment and there is a staff concern that these patients may present a risk to themselves and to other people, they are more likely to be dissatisfied and complain more, for that reason, a proper documented care plan including section paperwork and assessment of risk should be written clearly in their notes in orde, to be able to provide an efficient and safe psychiatric environment.

The study also highlights the importance of good communication and effective persuasion skills which may reduce the use of section 5(2).

Nearly 60% of the patients warranted section 2,3 of the Mental health Act for further assessment and to management.

The Limitation of the study

The study was a retrospective study which reviewed a six months period of admission. It would have been more informative to carry out a prospective study and interview patients to assess their views about the section.

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Conflict of interest: None to declare.

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