Effect of recent changes to the Mental Health Act 1983 on sections and appeals: possible unintended consequences

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Aims and method We examined the effect on civil sections and the rate of appeals against them of the amendments made to the Mental Health Act 1983 as a result of the Mental Health Act 2007. We gathered data for the year before and after the introduction of these changes.

Results We found increased use of Section 2 (56.8% before and 65.8% after ($P<0.001$)) and decreased use of Section 3 (39.5% before and 31.2% after ($P<0.001$)). The number of appeals against civil sections decreased (697 before and 692 after) but there was an 8.0% increase in the proportion of appeals to mental health tribunals. There was a decrease in admissions under these sections (817 before and 733 after).

Clinical implications These changes may be unintended consequences of the new law, resulting in increased workloads for psychiatrists and costs to the National Health Service.

Declaration of interest None.

The Mental Health Act 1983 allows for the compulsory detention in hospital of individuals with a mental disorder, either in the interests of their own health or safety or for the protection of others. Part two of the Act contains sections that allow for civil detention. Section 2 allows detention for 28 days for assessment and/or treatment, Section 3 allows detention for 6 months for treatment, and Section 4 allows detention for 72 h in emergencies. In the case of Sections 2 and 3, two doctors must complete medical recommendation forms and an approved mental health professional (AMHP) must complete a third form.[1] Aside from people who are already in-patients, assessment for these sections may be carried out in the community, in accident and emergency departments or in Section 136 suites in the case of those detained in public by the police. In England there were 24 485 admissions to National Health Service (NHS) facilities under civil sections during 2008–9, making up 19.5% of total admissions. Of these, 63.0% were under Section 2 and 34.1% under Section 3.[2]

The Mental Health Act 1983 was significant in seeking to enhance patients' civil rights by encouraging appeal against detention. Such appeals may be to a mental health tribunal or hospital managers. Previous studies have found appeal rates between 22 and 50%,[3–5] with individuals who have been previously detained more likely to appeal.[6] As well as appeals initiated by patients themselves, the Act requires that automatic referrals to the mental heath tribunal are made on behalf of detained patients at certain time intervals.

The Mental Health Act 2007 was an act amending the Mental Health Act 1983 and the changes came into force on 3 November 2008.[7] In particular, it introduced the 'appropriate medical treatment test', replacing the 'treatability test' as one of the criteria for detention under Section 3. Accordingly, the medical recommendation forms for Section 3 have been amended with an additional part requiring that the doctor specify a hospital or hospitals at which the individual may be detained.[8] It can pose a difficulty in areas with many possible destination hospitals, since a bed has often not yet been identified at the time the first medical recommendation is completed. Anecdotal accounts from colleagues suggested that this change may have resulted in individuals being detained under Section 2 where Section 3 would have been used previously.

Individuals being detained under Section 2 rather than under Section 3, because of the need to specify a hospital or hospitals at which the individual may be detained, would imply a departure from the 2008 Mental Health Act Code of Practice. This makes clear that Section 3 should be used where the individual's mental disorder, treatment plan and likelihood of accepting voluntary treatment are already established.[1] Moreover, use of Section 2 in place of Section 3 may be expected to have led to an increase in appeals. This follows because a person detained under Section 2 that is then converted to Section 3 can appeal against both

sections, which would not be the case had Section 3 been used initially. The cost of mental health tribunals to the NHS and government departments is substantial.[9,10]

Method

We gathered data retrospectively for admissions under section and appeals from the Mental Health Act Office of a South London mental health trust. This trust covers a local population of 1.1 million people, and during the study period had in-patient beds spread over six different sites. We obtained data for total admissions, broken down by age and gender, from the computerised clinical records system. We gathered data for two time periods. Period one was the 365 days before the introduction of the changes to the Mental Health Act 1983 (as a result of the 2007 Act) and period two the 365 days afterwards. We gathered numbers of admissions under civil sections (i.e. Sections 2, 3 and 4) and numbers of appeals against these sections. We broke down appeals by section and whether they were to mental health tribunal or hospital managers. We excluded appeals against supervised community treatment orders as they did not exist before the amendments to the 1983 Act.

Results

The total number of admissions fell from 4079 for period one (2067 male and 2012 female) to 3723 for period two (1818 male and 1905 female). The mean age of admissions remained similar at 43.4 years (s.d. = 15.5) for period one and 42.2 years (s.d. = 15.7) for period two. The number of admissions under civil section fell from 817 (20.0% of total admissions) for period one to 733 (19.7% of total admissions) for period two. Taking both periods together the proportion of total admissions that were under civil section was 19.9%.

Table 1 Number (%) of admissions under civil sections of the Mental Health Act 1983

	n (%)	
Section	Year before changes to Act	Year after changes to Act
2	464 (56.8)	482 (65.8)
3	323 (39.5)	229 (31.2)
4	30 (3.7)	22 (3.0)
Total	817	733

The data for admissions under civil section show a significant increase in the proportion under Section 2 (one-tailed two-proportion z-test $z = -3.61$, $P < 0.001$) and a significant decrease in the proportion under Section 3 (one-tailed two-proportion $z = 3.40$, $P < 0.001$), shown in Table 1. There was a 0.7% decrease in number of overall appeals against civil section, shown in Table 2. There was a 2.0% increase in the proportion of these that were against Section 2, which does not reach significance, shown in Table 2. We noted *post hoc* that there was an 8.0% increase in the proportion of appeals that were to mental health tribunals (two-tailed two-proportion $z = 2.86$, $P = 0.0021$), shown in Table 2.

Discussion

We have found an increase in admissions under Section 2 and a decrease in admissions under Section 3 after the introduction of the changes to the Mental Health Act 1983. Our data encompass a large sample size and are gathered from reliable sources. The proportion of admissions that were under civil section and the proportions of these under Sections 2 and 3 in our sample are comparable to NHS figures for England as a whole.

There are several possible reasons for the shift away from Section 3 towards Section 2. First, there is the change in the Section 3 first medical recommendation form, requiring that the doctor specify the destination hospital. The effect of this change may be amplified in a complex trust with many possible destination hospitals and may include wasted time and resources as a result of section forms having to be rewritten. One interpretation of our data is that this change is in some cases prejudicing the choice of section used to admit an individual. Second, it is possible that there has been a change in attitudes towards initial admission under Section 3 on the part of doctors and AMHPs. The Code of Practice clearly indicates the use of Section 3 when a patient and their likely treatment are already known, and conversely the use of Section 2 when this is not known and there is a need for a new assessment to formulate a treatment plan.[1] However, not all agree with this position. In particular, Jones presents several arguments for always admitting initially under Section 2, with subsequent conversion to Section 3 if necessary.[11] A future study might examine attitudes to this issue among AMHPs and doctors. Third, the decrease in Section 3 admissions could result from fewer well-known patients presenting for admission. One possible cause is the introduction of supervised community treatment orders.

Table 2 Number (%) of appeals against civil sections

	n (%)					
	Year before changes to Act			Year after changes to Act		
Section	Tribunal	Managers	Total	Tribunal	Managers	Total
2	134	38	172 (24.7)	161	24	185 (26.7)
3	305	220	525 (75.3)	330	177	507 (73.3)
Total	439 (63.0)	258 (37.0)	697	491 (71.0)	201 (29.0)	692

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However, this does not account for the increase in Section 2 admissions. If this increase continues it will mean greater cost to the NHS in time and money, both because of the need for more Mental Health Act assessments as more individuals are requiring conversion from Section 2 to Section 3, and because of more appeals being made as people appeal against both sections.

We did not find the expected increase in total appeals. This may be because of the decrease in overall formal admissions. We note that the small decrease in appeals is out of proportion to the large decrease in formal admissions. This could be the result of an increased rate of appeal as a result of more people being initially detained under Section 2 with later conversion to Section 3. A more detailed study that extracted such cases from the records would be required in order to establish this. The shift in appeals away from Section 3 towards Section 2 is in line with the corresponding shift in detentions.

There has been an increase in applications to mental health tribunals. One possible reason lies in amendments introduced to the Mental Health Act 1983 relating to the system for automatic referral. First, under the original 1983 Act hospital managers had to refer an individual to the tribunal at 6 months from the beginning of detention for treatment under Section 3. The 2007 Act amendments altered this so that referrals must take place at 6 months from the day on which the individual was first detained, whether under Section 2 for assessment or Section 3 for treatment. Second, the original 1983 Act required that subsequent referrals are made when 3 years have passed and the person's detention is being renewed. The 2007 Act amendments remove the link between subsequent referrals and renewal of detention, so that the only requirement is that the individual's case has not been considered by the mental health tribunal in 3 years. It is not clear why there has been a decrease in appeals to hospital managers. These changes deserve further examination, especially in view of the greater cost of mental health tribunals. A future study might survey patients to see whether mental health tribunals are perceived as fairer than hospital managers.

This study has some limitations. Due to availability of data and resources we looked at the number of appeals made rather than the number of tribunals and hearings actually held. It is possible that there has been a change in the proportion of appeals that actually reach this stage. This study only covered one mental health trust in an urban area. The results may not generalise, especially to more rural areas where there may be less choice of hospitals to admit to and hence less difficulty specifying this on the medical recommendation form. Finally, it is possible that there may be a time-lag between the introduction of the amendments to the Act and consequent changes, because of practitioners taking time to adjust to the new forms and practices. This could mean that the eventual changes are actually greater than those observed. Nevertheless, this is the first study to examine the effect of the amendments made to the Mental Health Act 1983 resulting from the 2007 Act on the choice of section used to admit patients. The results indicate that further research is warranted to see whether they are replicated and to clarify the causal relationship between the changes introduced and the changes in practice observed.

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