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## Difficulties with use of the Mental Health (Scotland) Act 1984 by general practitioners in rural Scotland

### AIMS AND METHOD

Anecdotal evidence suggests that considerable difficulties are experienced in rural areas by isolated general practitioners, when detaining patients under the Mental Health (Scotland) Act 1984. The aim of this study was to identify the range and extent of these difficulties in a structured way, and to identify ways of responding to them. A postal questionnaire was sent to 85 general practitioners in a sparsely populated

area of Scotland to assess their experience of emergency detention.

### RESULTS

The questionnaire response rate was 62%. Considerable difficulties were recorded from those who responded, notably their lack of support with clinical management during the delay between the patient's detention and the arrival of psychiatric staff, the lack of satisfactory places of safety for the patient during this period,

and the difficult logistics of safe and satisfactory transport to hospital.

### CLINICAL IMPLICATIONS

Rural general practitioners and their patients appear to be disadvantaged through lack of coordinated help in the management of inherently difficult and risky clinical situations. Even without additional resources, the process could be improved through coordinated, multi-agency action plans which take account of local conditions.

The emergency detention of a mentally ill person in the community is difficult under most circumstances, but especially so when the place of assessment by the general practitioner is remote not only from the hospital to which the patient is being referred, but also from professional support. This situation is typical of many rural areas in Scotland, and the difficulties encountered by general practitioners in such areas have been commented upon by the Mental Welfare Commission for Scotland (2001). As the percentage of people with mental health problems being cared for in the community rises, and with the increasing emphasis on the principle of 'reciprocity' (attention to patients' rights and amenity in proportion to the extent to which liberty is restricted), an understanding of – and attention to – the particular problems of rural areas becomes more important.

This paper reports the results of a survey of all general practitioners in the district of Argyll and Bute, a scattered rural catchment area some 7000 km<sup>2</sup> in size on the west coast of Scotland, including several offshore islands. The psychiatric hospital for this district is situated in Lochgilphead, and is up to 130 km distant from some of its catchment boundaries. The survey concentrated on experiences with emergency detention of patients under the Mental Health (Scotland) Act 1984, but also sought views about elective admission and the management of patients living in the community on extended leave during long-term detention.

### Method

A questionnaire survey was conducted of all 85 general practitioners in the Argyll and Bute Mental Health Directorate catchment area. The two-page questionnaire comprised 18 questions, and had a two-part structure: the first part addressed practical issues encountered during emergency detention, and the second addressed

practitioners' experiences with clinical responsibility for patients on extended leave (copies of the questionnaire are available from the authors upon request). The questionnaires were sent by post, and were followed up by polite telephone reminders to non-responders 2 weeks later.

For most of the numerical data, simple percentages were calculated and given the non-normal distribution of other data. The median and range are given.

### Results

The response rate was 62%, which compares favourably with previous surveys of this topic (Mental Welfare Commission for Scotland, 2001). The 53 respondents were experienced general practitioners, with a median of 10 years' practice in their current location (range 2 months to 33 years), but their actual experience of the process of detention was generally very limited. The great majority (86%) reported ready availability of the appropriate forms and guidance notes. Most detentions occurred in the patient's own home, but over a third of respondents had detained a patient in one of the small community hospitals scattered throughout the district, and a quarter had done so in a police station (Table 1). Other sites reported were fields, roads, and campsites for travelling people. Almost all the respondents stated that they informed patients when they were being detained, although a third expressed concern over their personal safety and stated that this worry tended to deter them from detaining a patient. Nearly half of the respondents were unaccompanied at the time of assessment and detention.

The most common problems reported by these general practitioners concerned what to do with the patient between the time of detention and the arrival of psychiatric staff to escort the patient to hospital, and the lack of timely availability of a mental health officer. Strong



opinions were expressed on issues such as difficulties in finding a local place of safety during the interim period, the need to resort to police custody, the risk of patients absconding, and the usual lack of availability of trained staff to be with the patient over this period.

According to the terms of the Mental Health (Scotland) Act 1984, consent to detention by the qualified doctor should be sought either from a mental health officer (an accredited member of the local authority social work department) or from the nearest relative. However, the majority experienced difficulty in obtaining timely assessment by a mental health officer, and nearly half tended to seek consent from an available relative. Only a small minority of doctors had proceeded without such consent – provision for which is made in the Act, if attempts to obtain consent have been made. On the thorny issue of whether detention had ever been used as a mechanism to secure hospital admission and provision of an ambulance and psychiatric nurse escort when the statutory requirements for informed consent had not been met, only one respondent admitted to this procedurally inappropriate, but in some ways understandable, tactic.

Experiences with long-term detention were sought within two categories: first, the provision of the medical opinion for non-emergency detention (under section 18 of the Scottish Act, the intended route to involuntary admission to hospital), and, second, experiences with patients on extended leave from hospital while under long-term detention. Nearly half of the respondents (24; 45%) had been involved in providing an opinion in relation to detention under section 18, but the discouragement from this involvement is powerful; in addition to making a full psychiatric assessment and completing the necessary

paperwork, the doctor may be required to justify the decision at a sheriff court, which may be a long way from the practice. It was therefore hardly surprising that 45% of respondents expressed reluctance to become involved in this non-emergency admission process. Asked about their perception of a general practitioner's clinical responsibility towards a patient on extended leave, more than two-thirds saw no difference between such patients and their other patients, but nearly a third felt that there was a difference.

## Discussion

The detention of an individual on the grounds of mental illness is a serious matter and it is an individual's right to have this procedure conducted in as sensitive, dignified and safe a way as possible. These rights should not be compromised by geographical remoteness, but they become more difficult to uphold in practice. This survey of general practitioners across a scattered rural catchment area on the west coast of Scotland is, to our knowledge, the first such study to be published, although a similar topic was recently addressed, through questionnaire, by the Mental Welfare Commission for Scotland (2001). The Commission's findings were broadly in agreement with ours, and raise serious issues regarding the implementation of the Mental Health (Scotland) Act 1984 in rural areas with poor access to psychiatric in-patient places and to appropriate and speedy professional support. By far the biggest problem encountered is the management of the often lengthy delay following the decision to detain until the patient can be safely escorted to hospital. Who is responsible for the patient during this period? How can a single-handed general practitioner actually guarantee the safe and satisfactory care of the patient during this time? How, within feasible resources, can patients' rights be honoured? Answers to these questions are difficult, but are important and urgently needed. A report from the Remote and Rural Areas Resource Initiative (RARARI) in Scotland suggests that local protocols describing a psychiatric emergency plan should be drawn up by National Health Service (NHS) boards and endorsed by all appropriate agencies and professional groups (Remote and Rural Areas Resource Initiative, 2003). The report urges that the plan should include statements defining the skills and competencies required of relevant staff, minimum staffing levels, and clear arrangements on the availability of mental health officers. However, the resource implications are considerable, given the cost inefficiency of having specialist staff readily available in remote and sparsely populated areas. Many of the general practitioners surveyed mentioned that the only available place of safety for patients awaiting psychiatric nurse escort was the local police cell. Not only is this unacceptable from the point of view of patients and their families, it is an arrangement about which the police feel very uncomfortable. Even local community hospitals may not have safe and private areas that are suitable for the purpose. The logistics of transport is an associated and frequent problem. Ambulances will not carry detained patients without a psychiatric nurse escort, leading to an

**Table 1. Emergency detention: experiences of general practitioners (n=53)**

	%	n
Training and experience		
Postgraduate training in psychiatry (%)	49	26
Guidance on the use of detention (%)	49	26
Number of patients detained in past 5 years (mean)	3.38	
Place of detention (%)		
Home	86	46
Community hospital	38	20
Surgery	19	10
Police station	24	13
Other	8	4
Detention process (%)		
Patient informed in advance	98	52
Doctor accompanied	58	31
Worry about personal safety	30	16
Difficulty until help arrives	82	43
Difficulty obtaining MHO	82	43
Usual source of consent (%)		
MHO	43	23
Relative	41	22
Neither	2	1
Both/either	14	7

MHO, mental health officer.



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inevitable delay while the psychiatric nurse travels by ambulance from the base hospital. Several respondents mentioned that helicopters could not be used because of local aviation protocols and safety issues. One person commented that most detentions are planned on the basis of completing the form as late as possible, in order to minimise the delay period. As in any situation involving several agencies, it is crucial to be clear about the assignation of clinical responsibility. Until the moment when the patient is collected for transfer by psychiatric staff, this must in our opinion be the patient's general practitioner, and that this responsibility should extend to medical preparation of the patient for transfer.

A large number of respondents (43; 82%) had problems gaining access to a mental health officer. This, as well as ready access to specialist advice, might be solved to some extent by video linkage between outlying practices and the psychiatric base unit. As far as non-emergency use of the power of detention is concerned, the main problem is again one of access, with general practitioners being reluctant to become involved in a process that might require them to absent themselves from their practice in order to provide an opinion in court. This undoubtedly explains the tendency for general practitioners to use emergency admission under section 24 rather than planned admission (section 18), but it is contrary to the intentions of Parliament when the Act was formulated. Patients on extended leave tend to be seen as no different from any other patients in terms of the general clinical responsibility of the primary care doctor, but this is not so for a sizeable minority. Although it was not possible on the basis of our questionnaire to explore this issue, it is to be hoped that this finding does not reflect a feeling that a detained patient on leave is the responsibility solely of the psychiatric service, rather than one shared with the primary care team.

We are conscious that the respondents to our questionnaire were confined to one particular rural district, Argyll and Bute. However, we have no reason to believe that the nature and extent of the difficulties we have described are peculiar to this district and cannot reasonably be generalised to other rural catchment areas. This assumption is supported by the RARARI report.

The impending implementation of a new Mental Health Act for Scotland (during the course of 2005) will not substantially affect the use of emergency detention by a general practitioner, apart from the fact that the practitioner will be required to consult, where practicable, a mental health officer but not a nearest relative. This will helpfully exclude family members from the perhaps distressing detention process, but it will place more onus on local authorities to provide reasonable access to mental health officers. The General Medical Services contract for general practitioners represents another forthcoming change that may increase the difficulties experienced in remote and rural settings. If rural practi-

tioners opt out of 24-hour on-call responsibility, there may be a need for out-of-hours cover to be provided in ways that would reduce the availability of a medical practitioner who is familiar with the patient and the family. In these new circumstances it will be particularly important that a multi-agency plan is in place for occasions on which the Mental Health (Scotland) Act 1984 may have to be invoked.

## Conclusions

There has always been ample anecdotal evidence of compromises to patients' rights during the process of detention in remote areas. This small survey represents a structured record of the real difficulties encountered by rural general practitioners, which render these compromises virtually inevitable. Solutions must be found in order to honour the principle of reciprocity, and this will require a serious commitment to proper resourcing of support for primary care teams from both the psychiatric service and from local authorities. Locally-based community mental health teams are an essential feature of the solution, enhanced by local psychiatric emergency plans of the sort recommended by RARARI, through which all potentially interested parties (such as primary care staff, the psychiatric service, the local authority, the police, the ambulance service and ferry operators) are consulted and signed up. Primary care and remote communities have for long been left to find any port in a storm.

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## Declaration of interest

None.

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