

There appear to be two reasons for this attitude. In the first place the procedure is easier to invoke (for example there is no need for the nearest relative to be involved prior to a S.2 application). Secondly, and of greater relevance, is the belief that it may be "kinder" to the patient to be able to say that detention under S.2 is for a maximum of 28 days, whereas detention under S.3 may be for six months. This attitude seems to be somewhat cynical in the case of a patient whose problems are already understood, and in respect of whom it is anticipated at the time of admission that S.2 will in due course be followed by S.3 as the disorder is unlikely to be relieved within the first 28 days.

One drawback of using S.2 is that, by the end of the 28 day period, the patient may be too well to be further detained but not well enough to be discharged. Such a patient may take his own discharge and, due to lack of insight, refuse further medical treatment, leading inevitably to rapid relapse and early readmission which, if again under S.2, may lead to a repetition of this unfortunate scenario.

Clearly if such a patient had been admitted under S.3 the treatment could have been prolonged for as long as appropriate, thus allowing the patient to enjoy an improved state of health with fewer distressful admissions.

To some extent this diversity of practice arises out of a lack of clarity in the Mental Health Act 1983.

The term "medical treatment" is expressed in S.145 to include "nursing care, habilitation and re-habilitation under medical supervision". Apart from that there is no statutory definition of either "medical treatment" or "assessment".

It will be generally agreed that medical treatment will at all times include an element of what may popularly be called "assessment". In other words, throughout the treatment programme a medical team will continuously monitor the course of the disorder and adjust the treatment as appropriate. It is clear from the context of S.2 that "assessment" for the purposes of the Act has a very particular meaning, and is not used in the popular sense described above.

An application for admission for assessment may be made on the grounds that the patient "is suffering from mental disorder of a nature or degree which warrants (his) detention in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period."

The use of the expression "for assessment (or for assessment followed by medical treatment)" gives rise to some difficulty of construction. On the face of it the expression would appear to imply that a patient admitted for assessment will not receive any medical treatment unless the assessment is completed before the section runs out when the assessment may be "followed by" medical treatment. However S.63 makes it clear that a patient detained under S.2 may be the subject of medical treatment without his consent at all times throughout the period of detention.

There can be but one explanation for this apparent contradiction and that arises out of the distinction between the criteria for admission under the two sections.

A patient may be admitted to hospital pursuant to S.2 if he suffers from *any* form of mental disorder. A patient may be admitted pursuant to S.3 only if he suffers from one or more of the four specific categories of mental disorders set out in the section, namely mental illness, psychopathic disorder, severe mental impairment or mental impairment.

The process of assessment is clearly the process of identifying the nature of the disorder from which the patient is suffering to establish whether the criteria for admission for treatment under S.3 have been satisfied.

In other words the use of S.2 is appropriate only for the purpose of diagnosis to establish the classification of the disorder and whether or not the provisions of S.3(2) are satisfied, i.e. to establish whether the nature or degree of the disorder make it appropriate for the patient to receive medical treatment in a hospital; and in the case of psychopathic disorder or mental impairment whether such treatment is likely to alleviate or prevent a deterioration of his condition; and whether it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained *under S.3*. ("under *this* section" S.3(2)(c)).

It is therefore wholly inappropriate to admit to hospital pursuant to an application for admission for assessment any patient suffering from a form of disorder the nature and degree of which are already known to the Responsible Authority. There can be no assessment if the nature and degree of the disorder is already established. Any contrary view would enable the compulsory admission under S.2 for the purposes of medical treatment, patients suffering from a form of disorder other than one specified in S.3. This might be considered to be an abuse of power.

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Section 37 of the Mental Health Act

DEAR SIRS

I read with interest Dr Singhal's letter on 'Section 37 of the Mental Health Act 1983' (*Bulletin*, January 1988). A patient detained in hospital under Section 37 may apply to the Mental Health Review Tribunal for his discharge in the second six months of detention and has a further right to do so within each subsequent period that the detention is renewed is clearly detailed in the Mental Health Act 1983. In his letter Dr Singhal raises the question whether such patients can apply to hospital managers for their discharge within the first six months. In my opinion the answer seems to be 'yes'. To this effect I would like to draw his attention to leaflet 8, *Your Rights under the Mental Health Act 1983* paragraphs 3 and 4 which clearly states:

Para 3: "The doctor will tell you when he thinks you are well enough to leave hospital. If you want to go

before the end of the six months or before he says you are ready, you will have to get the agreement of the hospital managers."

Para 4: "If you think you should be allowed to leave hospital, you should talk to your doctor. If he thinks you should stay, but you still want to leave, you can ask the hospital managers to let you go. You should write to them to ask them to do this."

This clearly indicates that a patient detained in the hospital on Section 37 can apply for his discharge to the hospital managers within the first six months of his detention. I was unable to find any reference to this effect in the Mental Health Act 1983 except in Section 23, sub section 4 which is rather vague and unclear about the powers of the hospital managers in discharging patients detained on Section 37.

I had an opportunity to discuss this issue with hospital managers and my consultant, who are all in agreement that a patient detained on Section 37 can apply to hospital managers for their discharge within the first six months and the hospital managers will ask for a psychiatric report from the responsible medical officer.

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Care of the pregnant drug addict

DEAR SIRS

Much of Dr Riley's information (*Bulletin*, November 1987, 11, 362-365) about the care of the pregnant drug addict is useful but some of it is confused and incomplete. The subject is becoming increasingly important and medical and paramedical staff caring for pregnant women are making errors and misjudgements precisely because of such incomplete and misleading advice.

Dr Riley tells us that because more people now take drugs on a recreational basis, "a smaller proportion of addicts show the full-blown picture of physical and mental deterioration associated with addiction in the past". Unfortunately, she does not differentiate between these very different patients. What she describes throughout is largely pregnancy in a 'street addict' who lives an illegal life and is likely, often simply as a result of this, to have a chaotic lifestyle and to suffer from malnutrition and infection. Like most of the literature on the subject, Dr Riley does not discuss healthy addicts who have regular supplies of clean drugs. As a result of this customary omission, a whole new batch of myths has developed.

The statement that "addiction of any serious degree nearly always implies the abuse of multiple drugs" is not true. There *are* addicts who will take any drug that they can get at any time but Dr Riley seems to imply that all heavy addicts are of this kind, which they are not. Many heavy addicts who are unable to afford enough of the drug to which they are addicted (usually an opiate) to satisfy their addiction try to dull the withdrawal symptoms by using

other drugs, often barbiturates or amphetamines, which are cheaper on the black market. If they can get enough opiate, they stop using other drugs. Also, let us not forget that 'street heroin' is often 'cut' with other drugs (along with flour, brick dust etc.) to conceal the fact that it contains so little heroin. These drugs may show up in a urine test but the addict herself has almost certainly been seeking only one drug and may be unaware of their presence.

What of the opiate addict who has a clean supply of drugs and proper medical care? Dr Riley seems to include her with the others, yet she is likely to be in good, often blooming, health. I can find no evidence that she is more likely than any other healthy mother to have a baby who is small-for-dates, premature or stillborn, though she may have an addicted baby. I have recently had a patient, a stable addict expecting her first baby after 15 years of stable marriage, who was badly frightened by obstetric and psychiatric staff. They told her repeatedly that she would have a premature baby and might well lose it. To encourage her, I took a bet with her that she would not. She delivered an 8lb baby at term. Ignorance on the part of her advisers, which could have come from reading Dr Riley's article had it not preceded it, caused that mother severe and unnecessary distress.

Dr Riley describes "physical complications" but again does not say that these are caused not by the drugs themselves but by a chaotic lifestyle dominated by the search for illegal drugs. Those whose lives and drug-taking are stable do not suffer from these complications. And although she refers to "withdrawal symptoms" in babies, she seems to think that adults take drugs only for fun. They may have started that way but once addicted, there is little fun for them. It is true that pregnancy can be a stimulus to stop taking drugs, sometimes permanently. Many chronic addicts manage to give up drugs during pregnancy because, like all normal parents, they want to do their best for their babies, and perhaps also to evade the social services.

Regarding the baby, Dr Riley mentions neither that the incidence and severity of withdrawal symptoms vary nor that some doctors believe that addicted babies do better on reducing doses of *opiate* than they do if given major tranquillisers. Many addict mothers believe this too and keep their babies away from doctors, sometimes treating them themselves with opiates until the infant is drug-free. Morally, this can be a responsible course of action but clearly it is dangerous. The mother embarks on it only because she has no confidence in her professional advisers or believes that they are hostile to her and may remove the child, or else simply because she dislikes the effect of chlorpromazine on her baby and believes that it is harmful. Also Dr Riley's injunction that only those on very low doses of methadone should breast-feed is based on unproven theory. Many addict mothers, and sometimes their doctors too, believe that breast-feeding is the best way gradually to introduce a baby, particularly a heavily-addicted baby, to a drug-free life. The baby is spared the pains of neonatal withdrawal, receives a diminishing supply of opiate through the breast milk and is eventually weaned naturally from both.