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Audit in practice

Section 5(2): who acts as the consultant's nominated deputy?

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Section 5(2) of the Mental Health Act, 1983 allows for the detention of an informal in-patient, should he/she wish to leave hospital but be considered a danger to him/herself or others if allowed to do so. The 72 hour period of detention allows time for a completed assessment for application for admission under Section 2 or 3 of the Act; it is not intended to replace this fuller assessment. The 1983 Mental Health Act introduced new provisions with regard to Section 5(2). The equivalent Section 30 of the Mental Health Act 1959 did not provide for a nominated deputy to act on behalf of the registered medical practitioner in charge of the patient's treatment (RMP). The nominee must exercise his/her own clinical judgement but, as indicated in the Code of Practice (1990), must contact the nominating doctor or another consultant to discuss the need for Section 5(2), before implementing it. The nurses' holding power, Section 5(4), was also a new provision in the 1983 Act.

There has been recent interest in auditing the use of Section 5(2). Studies within specific hospitals have described the frequency of employment of Section 5(2), the characteristics of those patients detained, and circumstances during which they were detained (Joyce *et al*, 1991; Brown, 1991; Pourgourides *et al*, 1992). There were differences between these studies regarding who was nominated to act as the RMP's deputy. Joyce *et al* (1991) recommended that the RMP should nominate one junior doctor as deputy during normal working hours and the on-call junior doctor outside normal working hours.

This study was undertaken to explore the variation between health districts in their interpretation of who is most suitable to act as the RMP's nominated deputy.

The study

A postal survey was undertaken. A seven item questionnaire exploring the use of Sections 5(2) and 5(4) was sent to the manager responsible for psychiatric services in each health district in England and Wales. This also invited comments as to any difficulties encountered with the use of Section 5. Mental handicap services were excluded. A letter indicating the intentions of the study was also sent to the Chairman of each Division of Psychiatry. After an interval of one month, a repeat questionnaire was sent to non-responders. Results from the returned questionnaires were collated, comments noted, and geographical variation in interpretation of who acts as nominee was assessed.

Findings

Where separate hospitals within the same district applied different policies, results for each hospital were recorded separately. This resulted in a study size of 199. There was a high response rate of 152 (76%). One district formally declined to participate in the study. Failure to respond occurred in 47 cases (24%). The 152 respondents had implemented Section 5(2) on 6,955 occasions and Section 5(4) on 843 occasions, over one year.

A summary of who acts as the RMP's nominated deputy is given in Table I. There was consistency as to who acted as nominee outside normal working hours, being the on-call senior house officer/registrar in 79% of cases. This duty was served by the on-call consultant in 12% of cases, the on-call senior registrar in 5% and some other doctor in 4% (associate specialist, clinical assistant, staff grade doctor, or general practitioner). During the day time, considerable variation in practice was found between districts. In 37% of cases, the on-call senior house officer/registrar acted as nominee; in 29% of cases this duty was served by the senior house officer/registrar who worked with that particular consultant. The on-call consultant acted as nominee in 11% of cases, and a specified covering consultant in 11%. There were other arrangements in the remaining 13%.

TABLE I
Who acts as the RMP's nominated deputy?

	On-call SHO registrar	*On-call consultant*	*Specified consultant*	*Specified SHO/ registrar*	*Other*
Outside normal working hours	79%	12%	—	—	9%
Within normal working hours	37%	11%	11%	29%	13%

In those hospitals where the nominated deputy is not a resident on-call doctor (61%), the situation might arise when neither RMP nor nominee was available to attend the patient that day. A wide range of alternative practices would then be employed by these different districts. In 20% (of the 61%) a suitably qualified nurse would invoke Section 5(4) of the Act until one of the two doctors was available, or the time came (usually 5 p.m.) when some other doctor was the nominated deputy. In the remaining 80% (of the 61%) an alternative doctor was nominated as deputy, being most usually the on-call senior house officer/registrar (37%) or on-call consultant (21%). These situations are rare.

Seven respondents sent copies of their local policy documents describing who acted as nominee, what their responsibilities were, and local usage of Section 5. Several other respondents indicated that problems had been encountered in the past with use of this section, but that these had been identified and addressed. Examples included confusion about who acted as nominated deputy, which patients could be detained under Section 5 (and therefore in service training provided to new junior psychiatrists) and the transfer of patients between hospital sites while detained under Section 5.

One respondent described a local criticism levied by the Mental Health Act Commission, regarding the use of Section 5(4). It had been considered that Section 5(4) was being used almost instead of Section 5(2), which placed nurses in a compromising position. This practice had since been addressed and changed. Four other respondents cited the use of Section 5(4) as a current problem; describing nurses as reluctant to use Section 5(4), feeling uncomfortable with this power, preferring to use powers of persuasion and common law for detention, until the arrival of the doctor.

Other current problems included difficulties in securing the assessment by an approved social worker within the 72 hours, especially at weekends and bank holidays (described by five respondents). Transfers between hospital sites under Section 5(2), for example between a peripheral psychiatric unit and a central psychiatric intensive therapy unit, in emergency situations was cited as a problem by four respondents. Several respondents indicated a change in practice away from using Section 5(2) as a short-term holding power, but three indicated that it was still viewed as the least restrictive option for detention including, for example, patients who needed emergency seclusion.

One consultant highlighted the problems encountered when RMPs are on leave; only one consultant may be nominated as deputy, but it is unrealistic for him/her to be available continuously for 24 hours a day over several weeks – however the Act does not provide for him/her to nominate an alternative deputy, for example at night.

Comments

Section 5(2) should be invoked when Sections 2 or 3 are not practicable, and patients so detained should be fully assessed by an approved social worker and the appropriate doctors, for a possible compulsory admission under the Act (The Code of Practice, 1990). Patients detained under Section 5(2) have no right of appeal. Consequently it is not viewed by the Mental Health Act Commission (1986) as the least restrictive option for detaining an informal patient, but a means of authorising detention to allow for assessment, as stressed in their second biennial report. This section can therefore be viewed as an emergency provision that plays an important role in clinical practice.

Outside normal working hours 79% of responding districts described the RMP as nominating the on-call senior house officer/registrar as his deputy. The Code of Practice (1990) described this as usual practice. The RMP is responsible for ensuring that the doctors he nominates are adequately trained and understand the power and purpose of the section. For most hospitals, it is usual for one junior doctor to be resident while on call; hence this arrangement clearly allows a speedy response to an emergency.

There is much variation between and within health districts as to who acts as deputy during the day time. The Code of Practice does not specifically address this point. Increasingly, psychiatrists are becoming community based. Attendance at mental

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health resource centres, day hospitals and centres, community team meetings, peripheral out-patient clinics and domiciliary visits all take the consultant and junior doctors away from the site of in-patient services. Services are organised differently in different parts of the country, and therefore who is available and suitably qualified to be nominated as deputy will necessarily vary between districts. However, for many hospitals, there would be an on-call junior doctor on the premises both day and night.

Ideally a doctor approved under Section 12 of the Act would fulfil the role of nominated deputy. However, that doctor will also have responsibilities to his/her own patients and therefore commitments which take him/her outside of the hospital, hence prohibiting an immediate response to hospital in-patients. Some districts have described reluctance in the use of the nurses' holding power; indeed, when there is a junior psychiatrist available one may question how appropriate it is for the patient to be detained by the nurse rather than the doctor, while the fuller assessment is completed. Section 5(4) becomes an essential emergency provision when there is no resident doctor.

Joyce *et al* (1991) suggested that the RMP should nominate one junior doctor to act as his deputy. Within the understanding of Section 5(2) as an emergency provision, for most hospitals, the doctor most able to fulfil this duty is the on-call junior doctor, rather than the junior who works with that consultant. This would provide for one doctor to be nominated to act as deputy every 24 hours, and could be specified in advance of this period of time. This doctor should receive a suitable induction as to his/her responsibilities as nominated deputy, and should attempt to consult the RMP or other consultant in all cases prior to implementing Section 5(2). Additionally, any available doctors or nurses who have knowledge of that patient should be consulted, dependent upon circumstances.

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"I had announced too my intention to resign and had determined to place my resignation in the hands of the Secretary on this occasion. But I may say, I am not aware that I have ever expressed any intention of resigning in January. The first information that I have had on the subject has been from Dr Harrington Tuke; but probably he knows my mind better than I do myself on that matter (laughter)". (Dr H. Maudsley, on leaving the Journal, 1877).

"Dr Coxe has been the life and soul of the Board of Lunacy, and that to him its admirable conduct and highly satisfactory working and results are mainly due". (Obituary of Sir James Coxe, originally in *The Scotsman*, 1878).

"who had known bewildered students, when a glass of blood, a glass of milk, and a glass of urine were placed before them, to confound the three in the most extraordinary manner". (Dr D. Hack Tuke citing an examiner, 1881).