Second Opinions for ECT and Extended Medication—Mental Health Act 1983

Attitudes of consultant psychiatrists and analysis of 200 second opinion visits

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The 1983 Mental Health Act made a requirement under Section 58 for a second opinion by an Appointed Doctor when a detained patient either did not understand the nature, purpose, and likely effects of a treatment or did not consent. The present study is confined to second opinions relating to ECT (electric convulsion therapy) and extended medication. It was noted in the Mental Health Act Commission's Biennial report[1] that requests for second opinions varied in numbers between different hospitals and psychiatric units. In 200 personal visits by the author a Treatment Plan by the Responsible Medical Officer (RMO), which is an indication of good practice in the operation of the Act, was written in the case notes in only 66 cases (33%) and then most often by a junior doctor. This finding has been reported generally. It seemed appropriate, therefore, to explore the opinions of Consultant Psychiatrists on the legal requirement for second opinion.

The study

Postal questionnaires were sent to Consultants in Adult Mental Illness in the South West, South East, North West and North East Thames Regions and the Wessex Region. They were asked if they agreed that the Mental Health Act 1983 should have made a requirement for a second opinion under Section 58, to state the number of times they personally had asked for a second opinion for ECT and extended medication, and whether the second opinion doctor had agreed with their plan of treatment or suggested modifications, and what these modifications were, and to give any general comments. The South West Thames Region was circulated first. After this the questionnaire was modified adding one question asking the Consultants whether they agreed that the second opinion doctor should consult a nurse, or a professional other than a nurse or doctor who was concerned with the medical treatment of the patient. This was added because experience with the working of the Act was beginning to show that delays and practical difficulties were arising from trying to nominate this professional.

Statistical analysis was straightforward except in the analysis of the number of second opinions requested for ECT and extended medication. These numbers extended from 0 to 16 and their distribution differed significantly from a Normal or Gaussian distribution as judged by the Kolmogorov-Smirnov test.[2] However by the same test their means per Consultant by Regions followed a normal distribution, hence means were used in analysis. In addition χ^2 was used for the analysis of proportions in categories.

The findings

Of the 406 Consultants who were sent questionnaires, 247 (60.8%) returned them: 100 (40.5%) were in favour of the Section 58 second opinion requirement without reservations; 39 (15.8%) were in favour of the principle but made various qualifications; 96 (38.9%) were not in agreement with the requirement in the Act and 12 (4.8%) expressed themselves as ambivalent, or not caring one way or the other. The opinions of the Consultant Psychiatrists excluding the 12 who were ambivalent did not differ significantly between the five regions studied ($\chi^2 = 11.7$, d.f. $= 8$, P = NS). There was no significant difference between the mean number of second opinions requested for ECT or for extended medication by those in favour of second opinions under Section 58 and those against. The mean number of visits per Consultant by Region was used for statistical calculation. For ECT the mean number of visits requested per Consultant in favour of Section 58, was 2.1 (based on 139 replies) with a mean of 2.5 visits based on the 96 replies of those not in favour of Section 58 (NS); for medication 1.5 mean visits requested by those in favour of the Act, 1.2 mean visits by those not in favour (NS). Of the 106 Consultants who were in favour of obtaining second opinions on the terms of the Mental Health Act 1983, and who were asked specifically if they agreed that the second opinion doctor should have to consult a nurse and a professional involved in the medical treatment of the patient, neither a nurse nor a doctor, 66 (62.3%) did not agree with this requirement as stated; 42 (39.6%) were in favour of a nurse being consulted, but not the other professional. Consultants in the South West Thames Region were not asked this question but, of 33 in favour of the Act in this Region, three made the unsolicited comment that they did not agree with this consultation process. A large number of general comments were made in the section of the questionnaire inviting these. Table I draws together those comments that could be categorised succinctly and which were made by four or more Consultants, 71 of these comments were adverse, 24 favourable.

I act as an Appointed Doctor for Section 58 of the Mental Health Act and in the period 27 January 1984 to 19 November 1986 had made 200 visits to 193 patients, seven being repeat visits. These visits were within the Southern

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TABLE I
Comments on second opinions

Comment	*Number commenting*
ADVERSE	
Patients suffer because of delay	16
Should be no obligation to consult other professionals	10
Feeling of anger over second opinion requirement	9
Cumbersome and bureaucratic	8
Undermines Consultant authority	7
Waste of public funds	6
Second opinion doctor should take over patient's treatment if he disagrees with RMO	6
Prefer to choose own second opinion	5
Criticism of second opinion doctor (from different speciality, conduct or inexperience)	4
Total	71
FAVOURABLE	
Second opinion helpful to RMO	15
Helpful but time consuming	5
Safeguards patients' rights	4
Total	24

Region of the Mental Health Act Commission; 139 patients were seen for ECT and 54 for extended medication. The mean age of the 139 patients visited for ECT was for the 109 females, 60.9 years (range 22–92); for the 30 males, mean 48.9 years (range 17–81 years). The mean age for the 22 female patients seen for medication was 43.8 years (range 25–82 years), for the 32 male patients 37.4 years (range 21–74 years). Of the 109 female ECT patients, 54 were over 65 years of age (49.5%), 39 over 70 (35.8%) and 13 over 80 (11.9%). Of this group, 27 (24.8%) were mute. The commonest diagnosis was psychotic depression. In 114 visits to female patients for ECT, in 91 cases (79.8%) the patients were not eating or drinking adequately; in many this had become life-threatening. Antidepressants had often been tried unsuccessfully and there were in any case no alternative treatments other than ECT. In nine of the visits the patients were on naso-gastric feeding, in six, intravenous. Unfortunately it is a rare event for psychiatric patients to be weighed either on admission or where the patients are refusing to eat or drink. There was no evidence of routine weighing, or even weighing as a follow up procedure where it seemed clinically relevant to do so. In only 11 visits was there a pre-illness weight available or ascertainable, but in some cases I was able to get the patient weighed at the time of the visit. In these 11 visits the average percentage weight loss was 16.8% (SE $\pm$ 3.3%) range 4.2–37%. In the male ECT patients, refusing to eat or drink was significantly less common: 13 of the 32 males showed inadequate nutritional intake, in the 114 females 91 were not eating or drinking adequately ($P=0.01$).

RMOs may use Section 62 to give emergency ECT before the second opinion doctor visits—this is a useful provision. In practice, Bank holidays and weekends may lead to delay in visits. Another reason for delay was the need to find a non-doctor, non-nurse, who knew something of the patient. In the 114 visits to female patients for ECT treatment had been started on 12 occasions (10.5%). In the case of 32 visits to male patients ECT had been started on two occasions (6.3%). Table II shows the diagnostic groupings. Depression predominated in the ECT group in both sexes with schizophrenia being the majority diagnosis in the medication group.

The professions of the non-doctor, non-nurse consulted in 200 personal visits were social worker on 59 occasions (79.5%), occupational therapist on 33 (16.5%), clinical psychologist on four (2%), probation officer twice (1%), and physiotherapist and Training Manager on one occasion each. These figures are similar to the ones published in the Biennial Report of the Mental Health Act Commission. The need to consult a non-doctor, non-nurse has generally given rise to two main difficulties: firstly delay, and secondly the need to find a professional genuinely involved in the 'medical treatment' of the patient. In 51 (25.5%) of 200 visits there was a serious problem in consulting the non-doctor, non-nurse. As the majority of visits are to elderly females for whom ECT is the treatment of choice, the social worker involvement was usually in completion of the application for Sections 2 or 3. The social worker involved was often from an Area Social Work office, not based at the hospital where the patient was admitted, and not in an ongoing role with the patient concerned. This social worker was often acting on an emergency basis and sometimes went on leave in the next few days, on a course or was off sick by the time the request to the Mental Health Act Commission's office was made.

The second most frequented consulted professional was the occupational therapist. The often very ill patients involved in second opinion visits do not go to occupational therapy but frequently in a desperate effort to find a professional to consult, occupational therapists were asked to go to the ward to acquaint themselves with a patient they had never seen previously, and some of them have met a mute, or almost mute patient. Many of these professionals consulted have been reluctant to be consulted, quite reasonably saying that they were not really involved with the patient, or could not make a sound professional assessment. Clinical psychologists were found to be very seldom involved with in-patients generally, and detained patients in particular. The problem of identifying a suitably involved non-nurse, non-doctor, was sometimes left to the RMO to solve, but this was not always successful, professionals being nominated without their knowledge and without ensuring that they actually had current knowledge of the patient. In

TABLE II
Diagnoses

	Depression	*Schizophrenia*	*Paranoid psychosis*	*Mania/ hypomania*	*Mental impairment or dementia*	TOTAL
Female ECT	93 (85%)	14 (13%)	2	0	0	109
Male ECT	24 (80%)	5 (17%)	1	0	0	30
Female medication	3	15 (68%)	3	0	1	22
Male medication	0	19 (59%)	0	5	8	32
Total	120 (62%)	53 (27.5%)	6	5	9	193

the 200 visits one social worker said ECT should not be given because the patient was too young, and one nurse expressed reservations about ECT being given before a longer period of antidepressant therapy had been tried. Apart from these, and perhaps surprisingly, the professionals supported the Treatment Plans.

Comment

The previous 1959 Mental Health Act was found to have shortcomings in practice and the 1983 Act was designed to remove some of these. It is not surprising that operational difficulties are occurring with some parts of the 1983 Act nor, in general, that there is a high level of agreement between the second opinion doctor and the Consultant in charge of the patient. There are really no effective alternatives to ECT in the very ill psychotic depressive who is not speaking, not eating or drinking. The medication group show a preponderance of schizophrenic patients whose illness has often been associated with dangerous anti-social behaviour, or acts harmful to themselves, with a very clear history that symptoms and behaviour have been much worse when they stopped medication. There were surprisingly few side effects from medication and in general levels of medication had been sensitively adjusted to optimum clinical response and minimal side effects.

The opinions of the Consultants over the principle of the second opinion requirements did not seem to affect the number of visits they requested. In practice the distinction between understanding the purpose and nature of the treatment and consenting to that treatment was seldom relevant as most patients had no insight into their illness, and many were either mute or incapable of rational discussion of their treatment. All patients were invited to discuss their treatment; very few did so.

The requirement to consult a non-doctor, non-nurse who has been professionally concerned with the patient's medical treatment leads to difficulties sufficiently often to suggest that this requirement should be deleted in an amendment to the Act. Patients who are very ill with depressive psychosis or schizophrenics not consenting to their medication are rarely in touch with professionals apart from doctors and nurses. Most, for example, are not the subject of current social worker involvement apart from the legal requirements to complete the Section forms detaining them, and most depressives are not fit to attend an occupational therapy department at the time they are seen for a second opinion, and most of the schizophrenic patients who refuse their medication also refuse social work and attendance at the occupational therapy department. In addition, it is seldom that the information obtained from the professional concerned is such as would influence the treatment the RMO wishes them to have.

(*see page* 314)

REFERENCES

[1] MENTAL HEALTH ACT COMMISSION (1985) *Biennial Report*. London: HMSO.

[2] NEAVE, H. R. (1981) *Elementary Statistics Tables*. London: George Allen & Unwin.

The Family Violence Research Group

The Family Violence Research Group is an interdisciplinary forum established in 1986 at the University of Leicester to pursue research interests in family violence and child abuse. The group is concerned with the investigation of the causes and consequences of child maltreatment and the study of prediction, prevention, and treatment of violence within the family. For further details and information, please contact: Dr Kevin Browne, Department of Psychology, University of Leicester, University Road, Leicester LE1 7RH (telephone 0533 522158; 0533 522481-messages).