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Trends in the use of the Mental Health Act: England, 1984-96

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The Mental Health Act 1983 provides legislation to ensure a consistent and comprehensive approach to the compulsory admission of psychiatric patients in England and Wales. Since the introduction of the act, the provision of service has changed: hospitals have closed and the care in the community programme has been introduced. Despite the reduction in the number of psychiatric beds available Department of Health data show a rise in the absolute number of compulsory admissions.¹ We aimed to determine the proportion of all psychiatric admissions that these compulsory "formal" admissions represent.

Methods and results

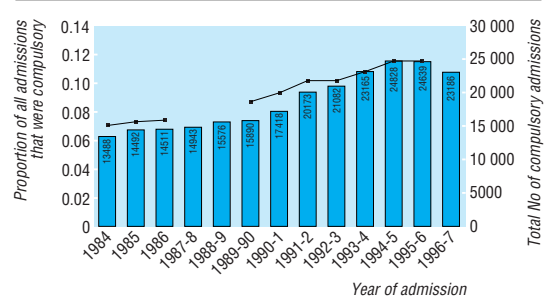
The Department of Health collects data from health authorities on compulsory psychiatric admissions, and these data were used to determine the proportion of all psychiatric admissions that were compulsory. Between 1984 and 1986 these data were presented for each calendar year. Since 1987 they have been presented for each financial year. Data were available from the Mental Health Enquiry from 1984 to 1986 and from the hospital episodes statistics system from 1989 to 1996. This system holds details of inpatients in NHS hospitals in England. Using these sources we calculated the

proportion of all admissions to psychiatric hospitals that occurred under the act. Data on the total number of psychiatric admissions were not available for 1987-9.

The total number of compulsory admissions has almost doubled, rising from 13 488 in 1984 to 24 639 in 1995-6. The number of all psychiatric admissions rose from 190 389 to 213 240 over the same period. Therefore, the proportion of psychiatric admissions made under the act has risen from 7% in 1984 to 12% in 1995-6 (figure).

Comment

There was a rise in the total number of admissions from 1984 to 1996, with increases in both the absolute number and the proportion of compulsory admissions. The quality of these data depends on accurate reporting by hospitals. There was discontinuity in the total number of admissions in 1986-9; in fact, they dropped slightly. We are unsure why this was so. It is possible that the data were collected in different ways and the change was artefactual. However, the number of compulsory admissions increased each year. Although the data that comprise the denominators were not ideal, as they came from two sources, the proportion of compulsory admissions increased steadily.



Bars represent the total number of compulsory psychiatric admissions to NHS facilities and the line represents the proportion of all admissions that were compulsory in England, 1984-96. Data on compulsory admissions not available for 1987-9

For 1989-96, when only one source of data was used for the denominator, the trend remained constant.

What explanations are there for the increase in compulsory admissions? Firstly, these changes may be due to alterations in the presentation of patients with psychiatric disorders. For example, there is some evidence that a higher proportion of psychiatric patients misuse drugs and alcohol, and this may lead to more florid presentations of psychotic illness.² Secondly, changes in the availability of beds during this period may have increased the threshold for admission and decreased the threshold for discharge. Between 1982 and 1992, approximately 43 000 fewer psychiatric hospital beds were available,³ and in inner city areas bed occupancy remains above 100% much of the time.⁴ The public's fear of violence by mentally ill patients and pressures to keep patients in hospital until it is "safe" to discharge them put further strain on the avail-

ability of beds. Delays in admission and treatment caused by bed shortages may mean that patients' illnesses are becoming more severe and that compulsory treatment is being initiated in cases in which informal admissions would previously have been possible.

These results have implications for resources in terms of costs and staffing. Compulsory admissions are more time consuming since they generally require that patients be assessed by two doctors and a social worker. Disturbed patients also require more intensive nursing and supervision. Patients admitted under the act have the right to appeal, and mental health tribunals are time consuming and costly. We suggest that the move to community care may have led to a paradoxical and unexpected increase in the use of coercion in the treatment of patients with mental illnesses.

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Drug points

Aseptic meningitis after treatment with amoxicillin

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The development of aseptic meningitis has been associated with various drugs—for example, non-steroidal anti-inflammatory drugs, ranitidine, carbamazepine, vaccines against hepatitis B and mumps, immunoglobulins, co-trimoxazole, and penicillin.¹⁻⁵ We report a case of aseptic meningitis after treatment with amoxicillin.

A 76 year old woman was admitted to our hospital with fever, headache, and neck stiffness. Five days before admission she had had a pretibial wound treated with amoxicillin-clavulanic acid. Long term treatment with aspirin, enalapril, and levothyroxine (thyroxine) had not been changed in the previous month. Two days before admission she had developed fever, headache, and neck ache.

On admission her general condition was poor, but findings on physical examination were normal except for neck stiffness. All laboratory findings were within the normal range. Cerebrospinal fluid showed pleocytosis with 63 cells (62 monocytes) and a slightly raised protein concentration of 0.47 g/l (0.15-0.45 g/l). No micro-organisms were found. She recovered with treatment of symptoms.

From her history we knew of two similar episodes in 1992 and 1995. Twelve and 6 days respectively after the initiation of antibiotic treatment with amoxicillin (with

and without clavulanic acid), she had been admitted to our hospital with the same symptoms of fever, headache, and neck stiffness. Cerebrospinal fluid had been examined during the first admission and also showed pleocytosis with 40 cells (38 monocytes) without an increase in protein concentration. No bacterial micro-organisms or serological signs of neurotropic viral infections had been found.

On the basis of these three confirmed episodes of meningitis after recurrent exposure to amoxicillin, with and without clavulanic acid, with repetitive negative testing for viral, bacterial, and mycobacterial micro-organisms, we diagnosed aseptic meningitis induced by amoxicillin. To our knowledge, this is the first well documented publication of such a severe side effect of a commonly used antibiotic.

The exact mechanism for the development of aseptic meningitis induced by drugs is not known, although hypersensitivity reactions and immunological mechanisms have been suggested.⁵

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