mentalwelfare commission for scotland

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VISIT AND MONITORING REPORT

Emergency detention certificates revoked by AMPs

An Analysis of emergency detention certificates revoked by approved medical practitioners

Report compiled for the Mental Welfare Commission by Mira Thomas and Karthik Bommu, temporary Commission Medical Officers and ST6 doctors in psychiatry of learning disability.

Contents

Our aim

We aim to ensure that care, treatment and support are lawful and respect the rights and promote the welfare of individuals with mental illness, learning disability and related conditions. We do this by empowering individuals and their carers and influencing and challenging service providers and policy makers.

Why we do this

Individuals may be vulnerable because they are less able at times to safeguard their own interests. They can have restrictions placed on them in order to receive care and treatment. When this happens, we make sure it is legal and ethical.

Who we are

We are an independent organisation set up by Parliament with a range of duties under mental health and incapacity law. We draw on our experience as health and social care staff, service users and carers.

Our values

We believe individuals with mental illness, learning disability and related conditions should be treated with the same respect for their equality and human rights as all other citizens. They have the right to:

- be treated with dignity and respect
- ethical and lawful treatment and to live free from abuse, neglect or discrimination
- care and treatment that best suit their needs
- recovery from mental illness
- lead as fulfilling a life as possible

What we do

Much of our work is at the complex interface between the individual's rights, the law and ethics and the care the person is receiving. We work across the continuum of health and social care.

- We find out whether individual care and treatment is in line with the law and good practice
- We challenge service providers to deliver best practice in mental health and learning disability care
- We follow up on individual cases where we have concerns and may investigate further
- We provide information, advice and guidance to individuals, carers and service providers
- We have a strong and influential voice in service policy and development
- We promote best practice in applying mental health and incapacity law to individuals' care and treatment

Why we did this study

The Mental Welfare Commission has a duty to report on the operation of the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the Act"). We also monitor the application of the principles of the Act and promote best practice in their use. Best practice dictates that individuals who are detained under the Act should be assessed by both an approved medical practitioner (AMP) and a mental health officer (MHO)[1].

The emergency detention certificate (EDC) is the route whereby individuals are detained in hospital under the Act for a period of no more than 72 hours by medical staff who are not AMPs, or when it is impracticable to obtain consent from a mental health officer (MHO). If an EDC is granted, it should be reviewed as soon as practicable by an AMP with a view either to revoking the certificate or progressing to a short term detention certificate (STDC).

The data we studied was from 1st April 2011 to 31st March 2012. The Commission received a total of 1786 notifications of EDCs out of which 476 (27%) were revoked after review by an AMP. A further 352 (20%) were allowed to lapse at the end of the 72 hour period of detention.

We examined all 476 EDCs granted during this period that were subsequently revoked by an AMP. We looked at the reasons why the EDCs were granted and why they were revoked to see if there was a correlation between the two. We also examined the variation in practice among NHS Boards. We specifically looked at MHO consent and the time it took for individuals to be reviewed by an AMP once they were detained.

We did not examine the 352 EDCs that were allowed to expire at the end of the 72 hour emergency detention period. Where the order expires, the revocation form submitted by hospital managers does not give reasons. It would have been impracticable for us to study these individuals, as we would have had to gain access to their case notes held in hospitals across the country.

This is a retrospective study looking at **four themes**;
1) Mental disorder recorded as the reason for detention;
2) MHO involvement;
3) Time and place of granting and duration of emergency detention;
4) Reasons for revocation of the emergency detention. We also looked to see if there were any variations in practice across the different health boards.

Note: in this document the term "individual" means a person with mental illness, learning disability or related condition. Other terms are used when directly quoting from legislation.

[1] http://www.scotland.gov.uk/Publications/2005/08/30105347/53579 (see para 24)

Overview of emergency detention – what the Act says

An emergency detention certificate is granted where the clinical situation will not permit the granting of a short term detention certificate. Its primary purpose is to permit a full assessment of a person's mental state.

All five criteria laid out under Section 36 of the Act must be met, namely

1. It is likely that the person has a mental disorder;
2. Because of that mental disorder it is likely that the person has significantly impaired decision making ability (SIDMA) regarding medical treatment of the disorder;
3. It is necessary as a matter of urgency to detain the person in hospital to decide what medical treatment is needed for the suspected mental disorder;
4. There would be a significant risk to the person's health, safety or welfare or the safety of any other person if the person was not detained in hospital;
5. Arranging to grant a short term detention certificate would involve undesirable delay.

A registered medical practitioner with a license to practice may grant an emergency detention certificate. It is not necessary for the practitioner to be an approved medical practitioner. The practitioner must be a fully registered medical practitioner within the meaning of the Medical Act 1983.

An emergency detention certificate may not be granted by a different practitioner from the one who carried out the medical examination. The medical practitioner must consult and seek the consent of an MHO to the granting of the certificate. It is expected that the MHO will attend and interview the individual, although there are rare occasions where the MHO may give consent by telephone[2]. Only where it is impracticable to consult an MHO or obtain his or her consent may a medical practitioner grant an emergency detention certificate without any MHO involvement.

The maximum detention period is 72 hours. This is counted from the time that the certificate is signed if the person is already in the hospital. If the person is admitted from the community, the period starts from the time of admission to hospital. The Mental Welfare Commission advises that a person who is placed on an EDC in an accident and emergency department should be regarded as a community patient, in which case the 72 hour period begins when the medical practitioner gives the form to the nurse responsible for the individual's admission. The certificate must be handed to "the managers of the hospital" in order for it to take effect. The role of hospital manager can be undertaken by a member of nursing staff on the admitting ward.

There is a duty to ensure that the person who is the subject of an EDC is seen by an AMP as soon as is practicable after the granting of a certificate. This is to ensure that the person is seen by a specialist, that the criteria for detention are reviewed and the ongoing need for detention assessed. The Commission considers it good practice that this examination should take place within 24 hours of admission / detention.

[2] http://www.scotland.gov.uk/Publications/2005/08/30105347/53579 (see para 43)

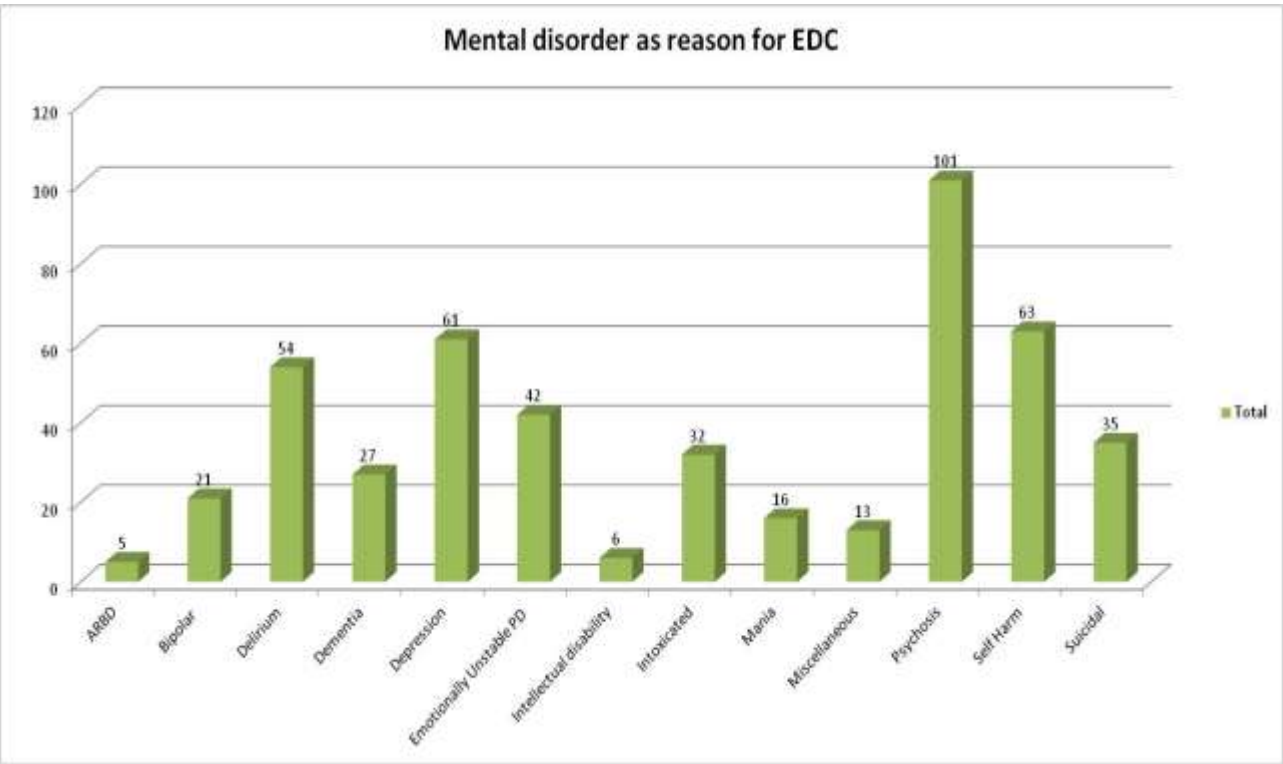
For the detention to be revoked the AMP has to be *no longer* satisfied that:
1. the individual meets the criteria for detention, or
2. It continues to be necessary for the individual to be detained in hospital.

There is no right of appeal against an emergency detention certificate.

What we found

Theme one: Reason recorded for detention

By far the most common reason recorded for emergency detention was suspected mental illnesses (45%). This includes psychosis (21%), depression (13%) and delirium (including delirium tremens) (11%). Other less common mental illnesses recorded were dementia (6%), bipolar affective disorder (5%) and mania (3%).



Of the 101 individuals with *psychosis*, it was clearly recorded that drugs were the cause of the psychosis in five individuals. These five individuals had their detentions revoked within 24 hours of the certificate being granted. A further 32 individuals had their detentions revoked within 24 hours of detention.

Mood disorder (depression, mania or hypomania and bipolar affective disorder) was recorded as the reason for detention for 98 individuals. For 61 individuals depression was recorded as the probable mental disorder, 16 individuals had mania or hypomania recorded and 21 individuals had bipolar affective disorder recorded. It was not clear on reviewing the forms with bipolar affective disorder recorded as the probable mental illness, what the individual's mood was at the time of detention. Of these, 25 individuals were detained in a mental health assessment unit, 24 in a psychiatric ward, 21 in A&E, 14 from their home, seven in a general hospital ward, five from a psychiatric clinic and two from a GP surgery. Of these 52 individuals had their detentions revoked within 24 hrs, 33 within

24 to 48 hours, 12 within 48 to 72 hours. *One individual had a revocation form filled in after the 72 hour period*.

Delirium was recorded as the reason for detention in 54 individuals. Of these, 19 were detained in a general hospital, 16 from their home, 14 in A&E, four in a mental health assessment unit and one in a psychiatric ward. Of these 54 individuals, 19 were recorded to have delirium tremens (DT), two had Diabetic Keto-Acidosis, one an acquired brain injury, one had self poisoned and one had schizophrenia. Out of the 19 individuals recorded to have delirium tremens (DT), six had their detentions revoked within 24 hrs, ten between 24 and 48 hours, three between 48 and 72. Out of the remaining 35 individuals, 13 had their detention revoked within 24 hrs, 15 between 24 and 48 hours and five between 48 and 72 hours. *Two individuals had revocation forms filled in after the 72 hour period of detention.*

Dementia was recorded as the reason for detention for 27 individuals. Two of these were recorded to have Huntington's disease. Nine had their detentions revoked within 24 hours, 10 within 24 and 48 hours, seven between 48 and 72 hours. *One had a revocation form filled in after 72 hours.* Fifteen individuals were detained from their home (these included nursing homes), five in a general ward, four in A&E and three in a psychiatric ward.

Emotionally unstable personality disorder was recorded as the reason for detention for 42 individuals. Of these, 25 (60%) had their detentions revoked within 24 hours, 10 between 24 to 48 hours and seven between 48 to 72 hours. Of these, 14 were detained in A&E, 14 in a psychiatric ward, seven in a mental health assessment unit, three each from their home or a general hospital ward and one in a psychiatric clinic. These figures are in keeping with what we expected to find; most individuals with emotionally unstable personality disorders present in a crisis situation which is resolved within a brief period, usually less than 24 hours.

Self harm (13%), “suicidal” (7%) and intoxication (7%) were recorded as “mental disorders”. Self harm includes self poisoning or injury. Individuals recorded as being suicidal were expressing thoughts of suicide, but had not acted on these thoughts.

Self harm was recorded as the reason for detention for 63 individuals. Out of these, 52 had overdosed (self poisoned) on illegal, over the counter or prescription medication. The rest (11) had presented with self harm by cutting that needed further treatment. Out of these, 29 were detained in A&E, two from a GP surgery, nine from their home, three in a mental health assessment unit, seven in a general hospital ward, one in a psychiatric clinic and 12 (25%) in a psychiatric ward. Of these, 41 had their detentions revoked within 24 hours, 14 between 24 to 48 hours and eight between 48 to 72 hours.

'*Suicidal*' was recorded as the reason for detention in 35 individuals. Nine were detained in A&E, six from their home, nine in a mental health assessment unit, five in a general hospital ward and six in a psychiatric ward. Of these, 19 had their detentions revoked within 24 hours, nine between 24 to 48 hours and seven between 48 to 72 hours.

We do not think that either “suicidal” or “self-harm” is an adequate description of why it is likely that the individual has a “mental disorder”. Both belong more properly under the heading of risk. The mental disorder which is considered likely to cause self-harm or suicidal thoughts should be documented as the reason for self-harm or suicidal ideas, e.g. mood disorder or acute stress reaction.

Intoxication was the reason for detention recorded for 32 individuals. This included alcohol and drug induced intoxication. Of these, 21 were recorded to be agitated and refusing treatment for an overdose or expressing thoughts of self harm. One had ADHD, one depression, two had symptoms of psychosis and one was post natal and in a crisis situation. There was no clear record of suspicion of a mental disorder (other than being intoxicated) in six individuals. Out of these 32 individuals, only three were detained in a psychiatric ward, 17 were detained in A&E, one in a GP surgery, two in their home, two in a psychiatric clinic, two in a mental health assessment unit and five in a general medical or surgical ward. Of these 18 had their detention revoked within 24 hours, 10 between 24 to 48 hours and four between 48 to 72 hours.

Use of, or dependence on, alcohol or drugs are not mental disorders under the 2003 Act. Section 328 of the Act makes this clear. However, other conditions that coexist with, or result from, alcohol or drug use may meet the definition of "mental disorder" under the Act. As above, this can include mood disorders and acute stress reactions. Again, we advise considering and recording these when justifying why it is likely that the individual has a mental disorder.

Intellectual disability was recorded as the reason for detention for six individuals. Of these two were detained from A&E, three from a psychiatric ward and one from their home. Five individuals had their detention revoked within 24 hours and one between 24 to 48 hours.

The *miscellaneous* causes (13) included six in a crisis situation, five of whom were detained in A&E and one in a psychiatric ward. Of these, four individuals had their detention revoked within 24 hours and two between 24 to 48 hours. The remaining seven included two who had anorexia nervosa as the reason for detention and had their detention revoked within 24 hours, one who had Asperger's syndrome whose detention was revoked between 24 to 48 hours, one had hypoxic brain injury as the reason for detention and this was revoked between 24 to 48 hours and one each had bizarre behaviour and irrational behaviour as the reasons recorded for detentions, both these detentions being revoked within 24 hours. Again, these last two are not adequate explanations as to why the medical practitioner considered it likely that these individuals had mental disorders. See the definition of mental disorder in section 328.

Theme two: MHO involvement

A) Consent recorded as given

Around half of the EDCs (239) recorded that an MHO had given consent. We thought that proper consent was obtained in 210 of these

- In only 26 (5%) was it clear on reviewing the form that the individual had been reviewed by a MHO before the EDC was granted.
- In 184 forms (39%) marked consent granted by a MHO, it was not clear on reviewing the form if the individual had been reviewed by a MHO or just a telephone conversation had taken place between the doctor granting the EDC and the MHO. We make the assumption that the MHO did review the patient, although the form does not specify whether or not the MHO attended in person.

There were 29 EDCs where we did not think the recorded MHO consent was accurately documented:

- In 25 cases (5%) consent was recorded as having been given, but it was clear on reviewing the form that only a telephone conversation had taken place. The MHO agreed that an EDC was reasonable under the circumstances, but had not personally reviewed the individual. This may not have been true MHO consent.
- The other four certificates documented MHO consent but the responsible medical officer's (RMO) name had been filled in the MHO's box. These may have been granted unlawfully.

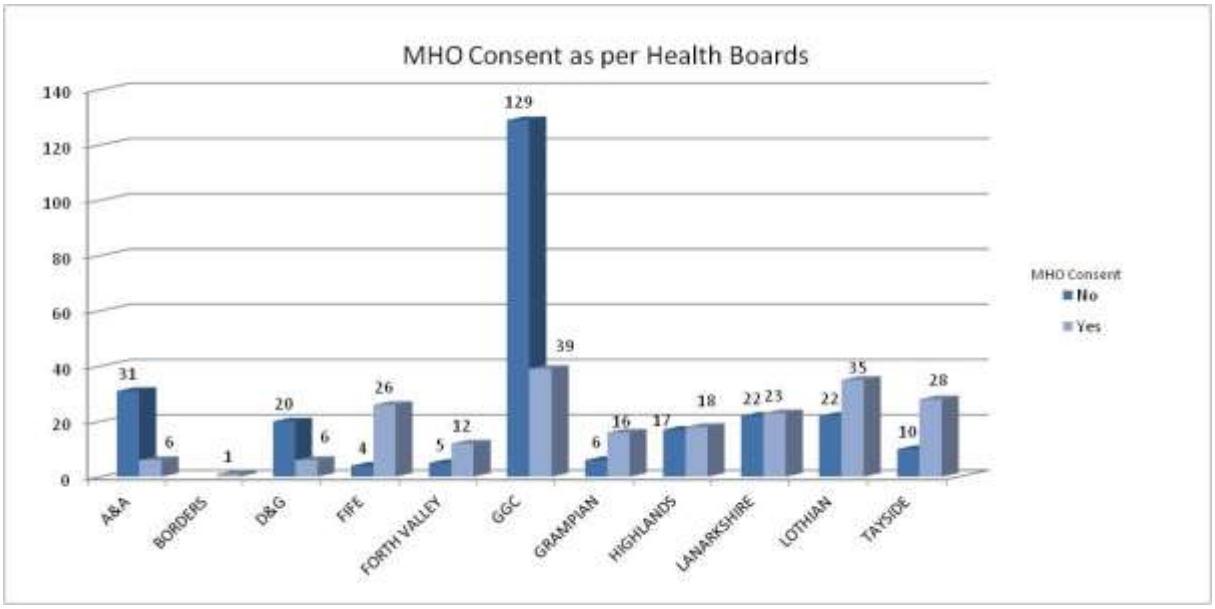
B) No consent recorded

No consent had been obtained for the other 237 ECDs. We found that:

- 81 EDCs (17%) were granted where the medical practitioner had clearly recorded that a telephone conversation had taken place with the MHO who was agreeable for the EDC to be granted under the circumstances, but had been unable to review the individual.
- 156 (33%) were granted where an MHO could not be contacted or where it was impracticable to either contact an MHO or wait for one, e.g. where the individual was trying to leave.

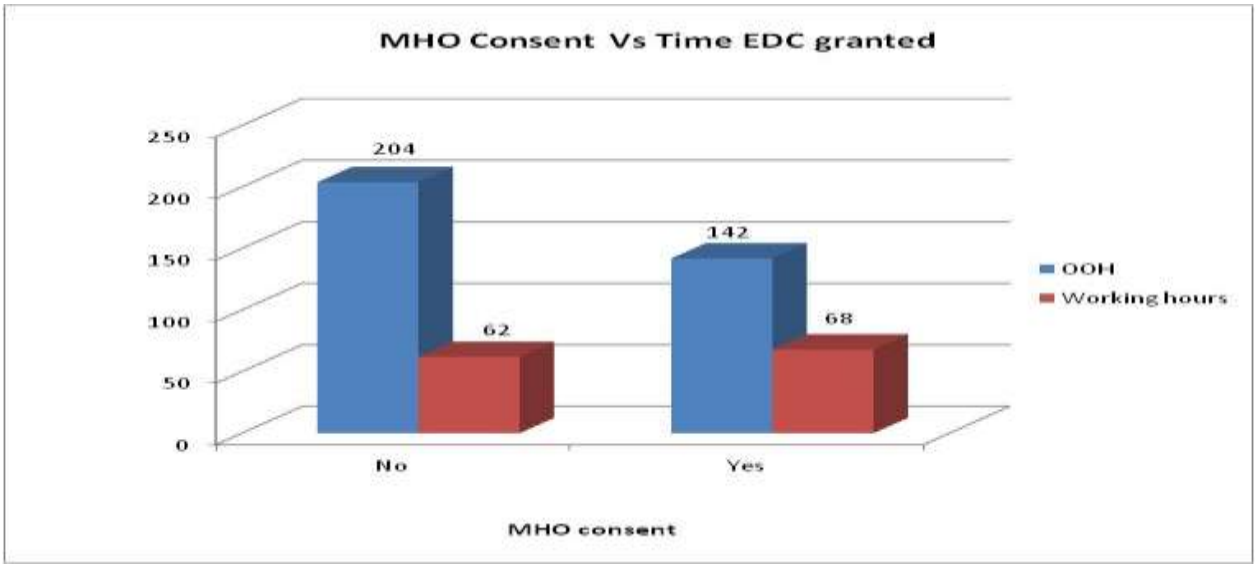
We therefore thought that consent was given for 201 EDCs (44%). Although it is good practice for the medical practitioner to record that they had a telephone conversation with the MHO, this on its own does not amount to consent if the MHO has not seen the individual in person except on rare occasions as per the code of practice.

The MHO should only consent to the detention over the telephone in exceptional circumstances: that is, only where the MHO already has a close knowledge of the individual and the recent case history or where the MHO has already seen the individual within a short time previous to the medical practitioner's call. Consent given in this way must be documented carefully.



As expected, Greater Glasgow and Clyde had the largest number of emergency detention certificates, in keeping with their large population.

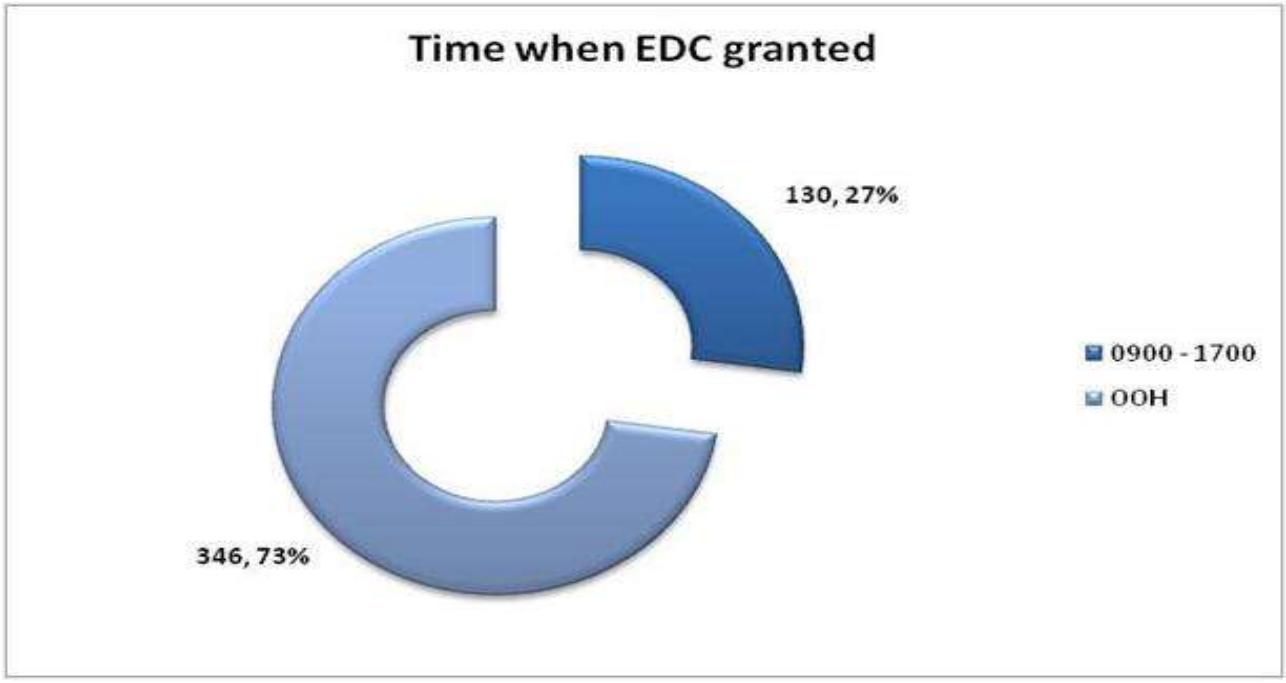
We found a wide variety in practice across NHS Boards when it came to MHO consent as seen in the graph. The Commission's annual statistical reports show that NHS Ayrshire and Arran and NHS Greater Glasgow and Clyde have the lowest proportions of EDCs that have MHO consent. For brief episodes of emergency detention, the proportion that has MHO consent is even lower in these Boards, and also in NHS Dumfries and Galloway. More work is needed to determine the extent to which this reflects the characteristics of the individuals or the characteristics of the service.

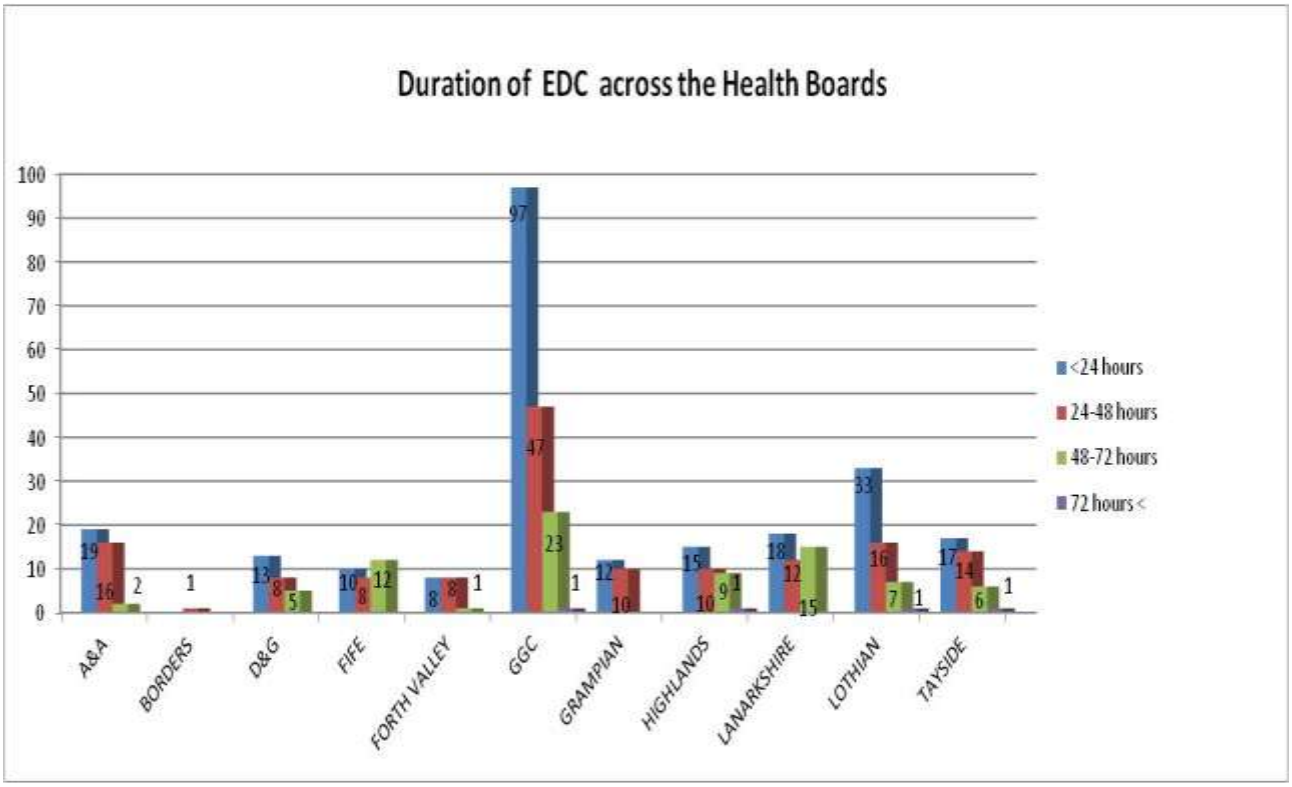


Of the 130 EDCs granted during working hours, 68 (52%) had consent from an MHO and 62 (48%) did not have consent from an MHO. Of the 346 EDCs granted out of working hours, 142 (41%) had consent from an MHO and 204 (59%) did not have consent from an MHO. During working hours, just over half the individuals had been detained with consent from an MHO. We had expected this figure to be higher. Out of working hours, two fifths of EDCs had consent from an MHO.

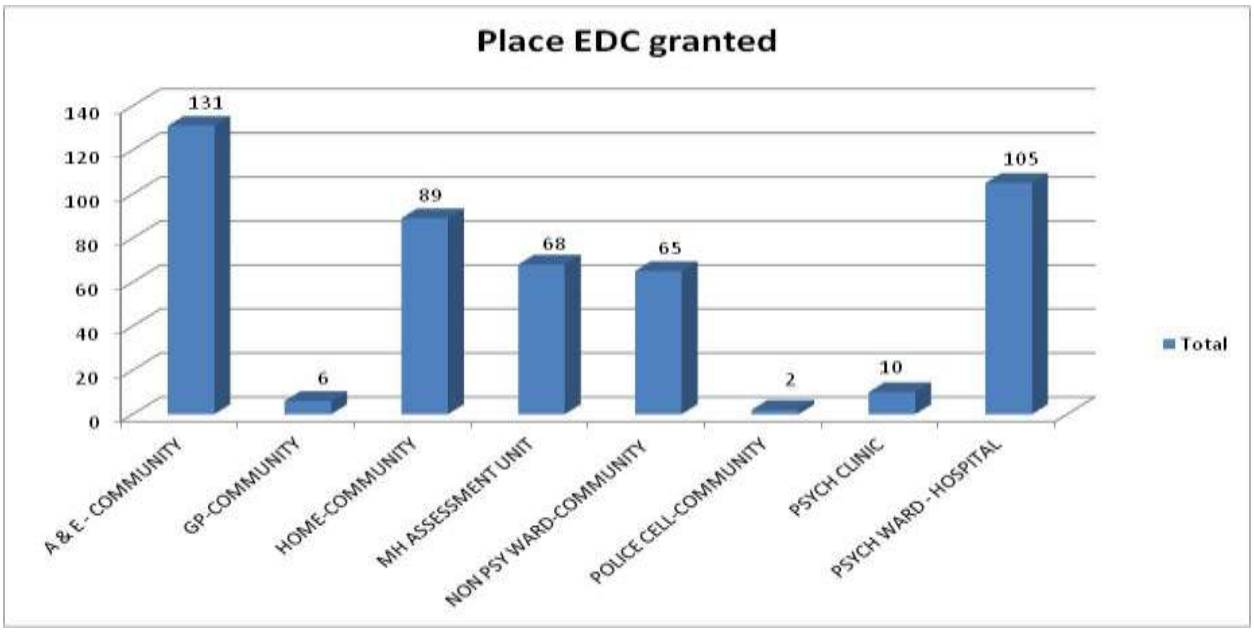
Theme three: Place and time of granting of EDC and duration of EDC

As expected the largest numbers of EDCs were granted in A&E. This is in keeping with the nature of the EDC.The majority of EDCs were granted out of working hours, which too is keeping with the nature of the EDC.





Of the 476 emergency detentions revoked, 242 were revoked within 24 hours of their detention (51%). A further 150 were revoked between 24 to 48 hours (32%) and 80 were revoked between 48 to 72 hours (17%). We noted that four individuals had a revocation form filled in after 72 hours of the detention period had lapsed.



The place of detention was as follows: 131 were detained in A&E (28%), 89 in their home (including nursing homes) (19%), 68 in a mental health assessment unit (referred to be seen by a psychiatrist by either their GP or CPN) (14%), 65 in a general hospital ward (14%), 10 in an out patient psychiatry clinic (2%), six in their GP's surgery (1%), two in the police cells and 105 were detained in a psychiatric ward (22%). We note that a fifth of individuals were detained in a psychiatric ward. This is lower than the figure we reported for all EDCs. Most people who were previously informal inpatients were detained further under STDCs.

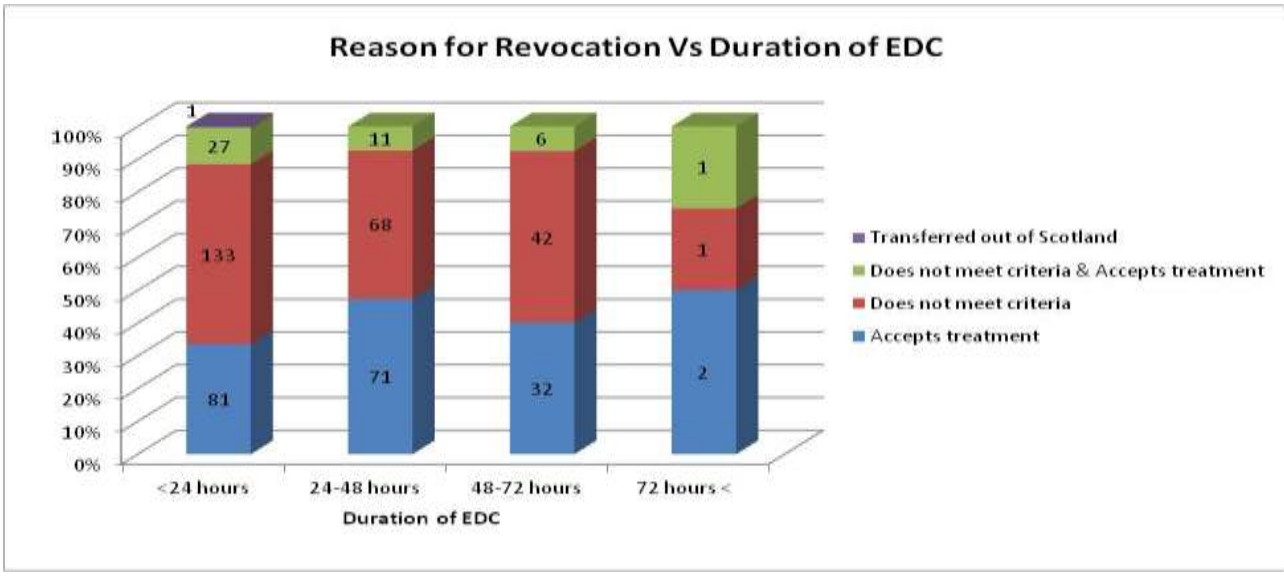
In total, 73% of the certificates were granted out of working hours. The EDC was granted in an emergency situation where availability of AMPs or MHOs was less. Of those certificates revoked, 51% were done so within 24 hours of the certificate being granted. This reflects a crisis being resolved or the individual recovering, e.g. from being intoxicated and agitated, and so no longer meeting the criteria for detention. A further 32% were revoked between 24 to 48 hours of being granted and 17% between 48 to 72 hours of being granted.

Four individuals had a revocation form filled in after the 72 hours following detention had lapsed. Unless this was a clerical error, these individuals may have been detained unlawfully for a short period beyond 72 hours. These were rare events, but we remind practitioners to make sure that they pay attention to the day and time that the EDC expires.

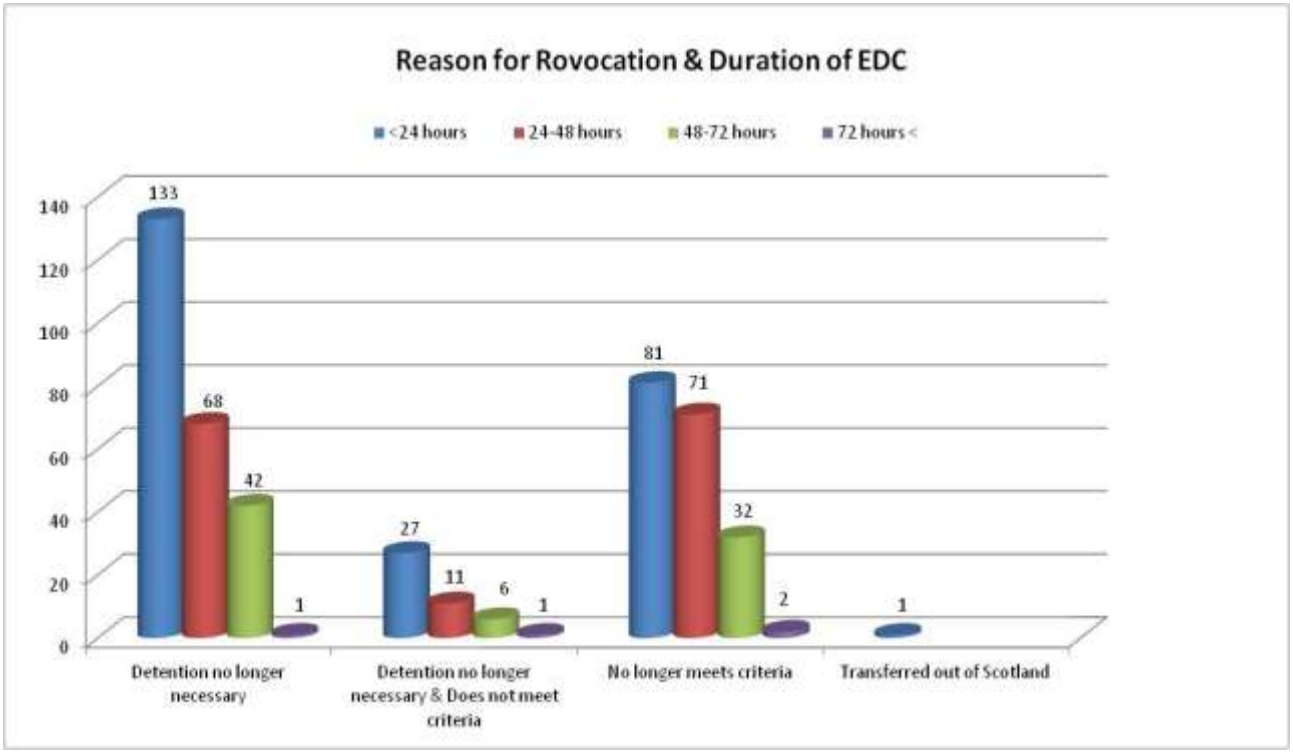
Comparisons among NHS Boards are difficult, especially where numbers are relatively small. NHS Fife and Lanarkshire may need to examine the availability of AMPs to conduct speedy reviews. Despite our concerns about the high numbers of EDCs without MHO consent in Greater Glasgow and Clyde, we were pleased to see that AMPs are conducting early reviews. This also applies to Ayrshire and Arran and Dumfries and Galloway, areas

where the proportions of EDCs with MHO consent were low. We commend most NHS Boards for ensuring early review and revocation where necessary.

Theme four: Reasons for revocation of detention



Out of the total of 476 individuals, 244 had their detentions revoked because it was no longer necessary for the individual to be detained in hospital (51%). Of the rest, 186 did not meet the criteria for detention (39%). The main reason given for no longer meeting criteria was that the individual was accepting treatment in hospital. We consider this as detention no longer being necessary as opposed to not meeting criteria, as an individual may accept treatment without regaining insight and may still have a mental disorder. The remaining 45 individuals no longer met the criteria for detention and did not need to be detained in hospital (9%). One individual had the EDC revoked because of transfer out of Scotland.



Of the 51% who had their detentions revoked as it was no longer necessary for them to be detained in hospital, the majority of these (55%) were revoked within 24 hours, a further 28% were revoked between 24 to 48 hours and the rest between 48 to 72 hours. One individual had a revocation form filled in after 72 hours.

Of the 39% of individuals who had their detentions revoked as they no longer met the criteria for detention, revocation was within 24 hours for 44%, between 24 to 48 hours for 39% and rest was between 48 to 72 hours. Two individuals had revocation forms filled after 72 hours of detention.

Of the remainder 9% of individuals who no longer met the criteria and no longer needed to be detained in hospital and so had their detentions revoked, the majority (60%) were revoked within 24 hours, 24% between 24 to 48 hours and 13% between 48 to 72 hours. One individual had a revocation form filled after 72 hours of detention. The individual who was transferred out of Scotland had their detention revoked within 24 hours.

	Reason for Revocation of EDC			
Reason for EDC	Detention no longer necessary	Detention no longer necessary & Does not meet criteria	No longer meets criteria	Transferred out of Scotland
ARBD			5	
Bipolar			21	
Delirium			54	
Dementia			27	
Depression			61	
Emotionally Unstable PD	24		18	
Intellectual disability	6			
Intoxicated	32			
Mania	16			
Miscellaneous	13			
Psychosis	90	11		
Self Harm	63			
Suicidal		34		1

Grand Total	**244**	**45**	**186**	**1**

We expected that the certificates would be revoked on necessity grounds if the other criteria (mental disorder, SIDMA and risk) were still met but the individual accepted treatment. Where, for specific aspects of treatment, the individual accepted treatment but did not have capacity to consent, this could be appropriately addressed via part five of the Adults with Incapacity (Scotland) Act 2000.

Examples of revocation on the other three grounds would be:

- The individual no longer had a mental disorder. If the individual was intoxicated, experiencing an acute stress reaction and suicidal on admission but the crisis quickly resolved (e.g. when no longer intoxicated), it could be argued that the mental disorder is no longer present.
- SIDMA is no longer present. The individual quickly regained the ability to make decisions about treatment.
- There is no longer a risk. Suicidal ideas or potential risk to others may have resolved

We were surprised by the reasons given for revoking the certificate. For example, individuals who were intoxicated or who had harmed themselves had their certificates revoked because detention was not necessary. We thought it was more likely that the other three grounds were no longer met.

Individuals who had diagnoses of depression or dementia had their certificates revoked because the other grounds were not met. We expect that the real reason was that they were agreeing, or at least not objecting, to receiving care and treatment. This would be most likely if the individual had a diagnosis of dementia, but raises complex issues of possible deprivation of liberty. At the time of writing, this matter is being considered by the Scottish Law Commission.

The ideal way to record this is a step-by step approach:

1. Does the individual still have a mental disorder as defined by the Act?
2. Is SIDMA still present?
3. Is there still a risk?

If any one of the above grounds is no longer met, the order should be revoked by recording that those grounds are no longer met. If they are all met but the individual accepts care and treatment, consider revoking the order if any treatment given in the absence of capacity to consent can be given under the Adults with Incapacity Act. Of course, if the first three grounds are not met and the individual accepts care and treatment, it is quite acceptable to record both on the revocation form.

When the Act is next amended, there will be an opportunity to review the forms. The distinction between the first three grounds for revocation and the necessity ground may be arbitrary and unnecessary. In the meantime, the above approach is the best way to record the reasons for revocation.

Recommendations

1. We strongly recommend that the reason recorded for the individual being detained in hospital should be the likelihood a mental disorder as defined by the Mental Health (Care and Treatment) (Scotland) Act 2003. “Intoxication” or “suicidal” are not mental disorders. Depression and acute stress reactions are. We suggest NHS Boards should include training about completing an emergency detention certificate for the junior doctors attached to the general hospitals and general practice surgeries at the time of their job induction.

2. Consent by a mental health officer (MHO) can only be given and recorded if the MHO has attended in person. In rare situations as described in the Code of Practice, the MHO may consent by telephone. Where the MHO is consulted by phone but cannot attend or consent, it is good practice to record that a conversation took place when outlining the reasons why there was no MHO consent. In such situations, medical practitioners should not record that the MHO gave consent or insert the MHO details into the boxes provided for this on the form. (When the forms are next revised, we will recommend a clear indication that the MHO attended in person.)

3. We again stress the importance of individuals being reviewed by AMPs as soon as practicable after being detained in hospital. Good practice dictates that this is within 24 hours. This will minimise individuals being detained in hospital unlawfully. Practitioners must ensure they are aware of when the order expires.

4. Approved medical practitioners should record the grounds for revocation by considering the mental disorder, SIDMA and risk grounds first. If they are met, but the individual accepts treatment without having capacity to consent, practitioners must comply with the requirements of the Adults with Incapacity Act.

Abbreviations:

ARBD: alcohol related brain damage

AMP /AMPs: approved medical practitioner / approved medical practitioners

EDC / EDCs: emergency detention certificate / emergency detention certificates

MHO / MHOs: mental health officer / mental health officers

RMO / RMOs: responsible medical officer / responsible medical officers

PD: personality disorder

STDC: short term detention certificate

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