mentalwelfare
commission for scotland

Emergency detention

A report into the emergency detention of people who are already in hospital
2012

MONITORING REPORT: EMERGENCY DETENTION OF PEOPLE WHO WERE ALREADY IN HOSPITAL VOLUNTARILY.

Who we are and what we do

We put individuals with mental illness, learning disability and related conditions at the heart of all we do: promoting their welfare and safeguarding their rights.

There are times when people will have restrictions placed on them to provide care and treatment. When this happens, we make sure it is legal and ethical.

We draw on our knowledge and experience as health and social care staff, service users and carers.

Our Goals

- Help individuals using mental health or learning disability services to get the best possible care and treatment

- Help people working in mental health and learning disability services to provide the best possible care and treatment for each person using those services

- To provide independent expertise in applying best ethical and legal practice in care and treatment

Our Values

Individuals with mental illness, learning disability and related conditions have the same 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 suits their needs

- lead as fulfilling a life as possible

Why did we carry out these visits?

It can be a traumatic experience to be admitted voluntarily to hospital but then prevented from leaving. It can also be a breach of an individual's right to liberty unless detention is lawful.

The Mental Welfare Commission has a duty to monitor the application of the principles of the Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act") and to promote best practice in their use. We also receive notifications of almost all types of certificate granted under the Act. We provide reports on the certificates granted and raise any matters that are of concern to us.

In 2010-11, we received notification of 1809 episodes of emergency detention. Of these, 1028 (56%) were said to be for individuals who were already in hospital at the time the certificate was granted. This year (2011-12), the figures are similar with a total of 1786 notifications of which 1019 (54%) are said to be for people who are already in hospital.

We have been concerned for a number of years that the proportion of emergency detention certificates (EDC) granted for people already in hospital is higher than we would expect. We therefore decided to carry out a specific monitoring visit programme to examine the reasons for this.

We undertook this review between July 2011 and March 2012. We identified all EDCs between 1/7/11 and 29/2/12 where the detaining doctor had indicated on page 4 of the EDC that the individual was already an inpatient. During this period, there were 1191 notifications of which 682 (58%) were noted to be informal prior to the application of an EDC.

We aimed to visit the hospitals where detentions took place to review the case notes and, where possible, interview the individual. In addition, we took the opportunity to review EDCs while visiting hospitals for other reasons.

In this report, the term "individual" means a person with mental illness, learning disability or a related condition. We use other terms only when quoting directly from the 2003 Act or case records. Where we have given individual case examples, we have changed some details of the individuals to avoid identifying them.

Emergency detention – what the law says

The Mental Health Act, under Section 36, allows the detention of a person in hospital for up to 72 hours if:

- It is likely that the person has a mental disorder;
- It is likely that the person has significantly impaired ability to make decisions about medical treatment;
- It is urgently necessary to detain the person in hospital to decide what medical treatment is needed

- If not detained, there would be a significant risk to the person’s health, safety or welfare or the safety of any other person;
- Arranging to grant a short-term detention certificate would involve undesirable delay

The EDC can be granted by any fully registered and licensed medical practitioner, who must consult a mental health officer (social worker with special training) unless it is not practicable to do so. If it is not practicable to consult or obtain consent from a mental health officer (MHO), the medical practitioner must explain the reasons on the EDC. Detention cannot go ahead if the MHO refuses to consent.

The 72 hour period of detention 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 code of practice states 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 with their admission to the ward. The certificate must be handed to “the managers of the hospital” in order for it to take effect. This role 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 approved medical practitioner (AMP) as soon as is practicable after the granting of a certificate. This is to ensure that the person is seen by a specialist and that the criteria for detention are reviewed. We consider that in most circumstances this should be within 24 hours of the certificate being granted. If the AMP is not satisfied that the criteria are met then the certificate should be revoked. If the criteria are still met then consideration should be given to the granting of a short term detention certificate (STDC).

Nurse’s power to detain – what the law says

We also examined the use of the nurse’s power to detain. Under section 299 of the 2003 Act, a registered mental health or learning disability nurse may detain someone who is in hospital and receiving treatment for mental disorder. This allows the individual to be detained for up to two hours in order that a medical practitioner can attend and conduct an examination. The two hour period is extended if the medical practitioner arrives during the second hour. The nurse must report the use of this power to hospital managers who must then inform the Commission within 14 days.

There is a form available to report the use of this power, the NUR 1 form. It is designed to record the fact that the power has been used. There is no requirement to complete the form before the power is used.

Summary of findings

We examined:

- Care planning in anticipation of a wish to leave
- Restraint of informal individuals
- Granting an EDC
- Reviewing an EDC

Our main findings were:

1. Around a quarter of the EDCs we examined wrongly stated that stated that the individual was already an informal inpatient. We consider the certificates to be lawful, but the result is an inaccurate picture of how emergency detention is used.
2. We found variations in practice where staff anticipated that an individual may wish to leave. Anticipatory plans for this are good practice although medical staff must take care to avoid statements that could be interpreted as “de facto” detention.
3. We found several situations where individuals were restrained and prevented from leaving hospital without proper recording and notification of the use of the nurse’s power to detain. Practice must improve in this area.
4. Responsible medical officers have a statutory duty to report the giving of urgent medical treatment to individuals subject to emergency detention. We found some instances where there was no record of this notification.
5. We found gaps in availability of approved medical practitioners (AMPs) and, to a lesser extent, MHOs outside office hours. NHS Boards and Local authorities should have arrangements in place which maximise the availability of AMPs and MHOs. Medical practitioners completing EDCs must document clearly why either or both an AMP or MHO was/were not available.
6. We found that some medical practitioners recorded MHOs as having given consent when they had been consulted by phone but were not able to attend. Medical practitioners and MHOs need to be clear about whether or not consent is being given in this situation. The MHO’s details should only be recorded on the form if it is clear that he/she is giving consent.
7. We found significant delays before individuals subject to an EDC were reviewed by an AMP, especially if admitted at the weekend. NHS Boards should ensure early reviews by an AMP in order to revoke an EDC if the criteria are no longer met.

As a result, we make the following recommendations to service providers:

1. Medical practitioners should not record individuals assessed on hospital premises as having been previously informal inpatients unless they had been admitted to hospital.
2. NHS Boards should ensure that medical and nursing staff follow good practice when preparing individual care plans which cover the circumstances where informal individuals decide that they wish to leave.
3. The making of the statutory notification to the MWC, is a legal requirement when the nurse’s power to detain has been used. Hospital managers must ensure that nursing staff comply with the law.
4. NHS Boards must ensure that medical staff act lawfully when treating individuals without consent. They should audit the use of “as required” or one-off prescriptions of psychoactive medication for informal individuals.
5. NHS Boards and local authorities should take note of the findings of this report. We would like to see action plans that address:

- Better round-the-clock availability of AMPs and MHOs (especially the former);
- Clear instructions to medical practitioners and MHOs on what constitutes consent and how to document it;
- Local audits of urgent medication administered under EDC to ensure proper reporting to the Commission.

6. NHS Boards and local authorities should endeavour to ensure AMP and MHO assessments of any individual admitted under an EDC as soon as practicable after admission. In our view, this should take place within 24 hours of admission.

We make two additional recommendations to the Scottish Government:

7. We repeat our recommendation previously made to the Scottish Government. A short holding power to allow full assessments by an approved medical practitioner and an MHO should be considered as part of revisions to the 2003 Act.
8. The Scottish Government should consider shortening the period of emergency detention to 24 hours where there is no MHO consent.

Detailed findings

1. Description of sample

Key message . Around a quarter of the EDCs we examined wrongly stated that stated that the individual was already an informal inpatient. We consider the certificates to be lawful, but the result is an inaccurate picture of how emergency detention is used.

Commission practitioners were able to review 221 of the EDCs notified during the study period. This represents a sample of 32% of the total notified. Of these, we found that 58 cases did not meet the criteria when we reviewed the case in detail because DET1 forms wrongly identified the individuals as having been an informal inpatient. People who were admitted after attending as an emergency for assessment, e.g. in accident and emergency departments or emergency mental health assessment clinics, were wrongly recorded as having been inpatients. The law does not say that the certificate must state whether or not the individual was previously in hospital on an informal basis. Therefore, we do not consider that this error makes the form unlawful.

Number of EDCs initially included in monitoring exercise	**221**	
Number of these EDCs that met criteria	163	74%
Number that did not meet criteria	58	26%

This finding may account for some of the apparent excess of use of EDCs for previously informal inpatients that we had observed. Applied to the annual figures,

this would result in revised percentages of 57% for those who were made subject to an EDC from the community and only 43% (compared with 54%) after being admitted informally.

Recommendation

Medical practitioners should not record individuals assessed on hospital premises as having been previously informal inpatients unless they had been admitted to hospital.

Number of EDC visits that met criteria for the monitoring study	**163**		
Number where individual not present	123		
Number where individual present	40		
	Number of patients interviewed	33	(82% of in were prese
	Number of patients not interviewed	7	Five were interview clined the c

This report therefore concentrates on the findings from the 163 cases which met the criteria. Issues which arose from the monitoring visits, whether or not the individual case met the criteria, have been dealt with as appropriate by the relevant practitioner.

Demographics

In general, emergency detention is used more frequently for women than men. Our sample is consistent with this finding. Of the 163 people who met the criteria for the monitoring visit, there were 94 women and 69 men. The age range was from 15 to 87 with the highest concentration, not surprisingly, in the 25-44 age group (46%). We saw people from all mainland NHS Board areas.

Table

Health Board	**Number of EDCs notified to MWC identified as “already in hospital”**	**Number included in the study**	**Number seen/or re-viewed**
Ayrshire and Arran	68	20	13
Borders	5	3	2
Dumfries and Galloway	23	7	7
Fife	37	1	1
Forth Valley	17	9	8
Grampian	14	2	2
Greater Glasgow and Clyde	248	56	35
Highland	56	7	6
Lanarkshire	97	63	45
Lothian	59	31	24
Tayside	58	22	20
Total	**682**	**221**	**163**

Ethnicity was recorded in 133 cases (82% of those reviewed). Of these the overwhelming majority were Scottish (127). As we were only able to interview 33 individuals much of this data has been derived from case note reviews and we were therefore dependent on the information contained within them.

Diagnosis

Diagnosis was recorded from the case notes. In 18 cases there was more than one diagnosis, with 17 noted as having two diagnoses and one person with three diagnoses. Only three people had no definite diagnosis at the time of our practitioners’ review. However, these reviews often took place some time after the end of the EDC.

Recorded Diagnosis	Number
Dementia	21
Other mental illness	114
Learning disability	7
Personality disorder	17
ABI	2
ARBD	6
ASD	1
Other diagnosis	12
Total	180
Diagnosis not yet determined	3

2. What individuals told us

We were able to meet 33 individuals and ask their views on the use of the EDC. Most people had been discharged by the time of our visit. Some people declined the offer of meeting us and giving their views.

Of those people we met, most had little detailed memory of the circumstances which led to them being placed on an EDC. Nineteen had almost no recall of the circumstances and ten had some recall, but not a lot of detail. Three people referred to wishing to harm themselves, and seven told us that they wanted to leave hospital.

Some individuals recognised that they had needed to be detained. Others described distressing experiences, especially if force or restraint was involved. We look into this matter later in the report. Here are some examples of what we heard from individuals.

Mr A said he was in a very confused state when he came into hospital. He could not really remember what happened at the time he was detained, or what the doctor or anyone else said to him. He said he had taken a lot of tablets the evening before his admission - his own painkillers, and some tablets which had been prescribed for his ex-partner who had left him. He had not been attempting suicide, but had been having difficulties sleeping. He thought it probably would have been the right thing to detain him if he was trying to leave. He was aware he is now on an STDC and has a letter explaining his rights, but he does not want to appeal the STDC.

Ms B said she had no recollection of what she was told when EDC granted. She said though that she could understand why order granted as she knows she was very intent on taking her life at the time she was admitted to hospital. She has subsequently been detained on a STDC and is now on a CTO, and knows she has

had information about her rights, and she had a solicitor representing her at her tribunal

Ms C was quite angry about the EDC and subsequent STDC. She is still not allowed to leave hospital and visits to the hospital are a problem for her husband who is physically ill. She believes her "fighting with staff" when they tried to dissuade her from leaving was a consequence of her medication. She recalls that when she tried to leave saying she wanted to see her family staff said it was too late (2AM), they would be in bed and also that she had spent very little time on the ward over recent brief admissions, and they wanted her to stay longer so they could properly assess her and help her. She acknowledged that she had been in hospital briefly several times over the last two months, and had not been actually there long enough for them to help her. She remembers she was punching and kicking at staff.

Ms D had trouble remembering the actual event but said she understood that she had just wanted to leave the ward at the time and go home. "I can just sit about all day at home just the same. I don't like it here and since I have been detained, I get followed round by nurses all day."

3. Care planning in anticipation of a wish to leave

Key message. We found variations in practice where staff anticipated that an individual may wish to leave. Anticipatory plans for this are good practice although medical staff must take care to avoid statements that could be interpreted as "de facto" detention.

<u>Why we looked at this</u>

We regularly give advice on visits to hospitals and in published reports about appropriate care planning and documentation in case notes, including what should be done in the event that an informal individual seeks to leave. We wanted to see how well services were adhering to this guidance.

<u>What we expect to find</u>

We have reproduced in Appendix B the section on 'De facto' detention" from the MWC's monitoring report *"Short Term Detention"*, March 2010. We expect to see statement to the effect that reassessment would be needed if the individual wishes to leave.

<u>What we found</u>

During review of the case notes of individuals in this EDC monitoring exercise, Commission practitioners saw examples of good care planning and careful, appropriate note entries in this area.

"If wishes to leave needs to be assessed for whether meets criteria for detention under MHA". Entry in case file.

"Note concerns through night. If continues to voice wish to be discharged then needs to be seen by doctor to review the risks and detainability." Entry in case file.

"Section in admission sheet asks 'what to do if wishes to leave' and information was recorded there that should be assessed to see if MHA required." Noted by MWC practitioner visiting Forth Valley Royal Hospital.

"There is a very good Psychiatric Assessment Form in use across the Hospital site - it covers all appropriate areas of enquiry for those who are admitted, and there is a section 'For voluntary patients, what is the management plan in the event of the patient wishing to leave prior to review by usual team?' In this case the entry is 'would require urgent medical review' "- which is what happened". MWC practitioner visiting Ailsa Hospital.

We were concerned and disappointed also to find a number of case note entries stating "Detainable if wishes to leave" or similar. Seven clear examples of this were recorded by MWC practitioners before the individual was detained.

6/9/11 – medical documentation from morning meeting: "definitely not going home".
6/9/11 - Medical entry by Consultant: "Requires inpatient care. Detainable under Mental Health Act if needed".
7/9/11 – Medical entry by Consultant: "Agitated last night. Keen to go to out last night to meet a friend. Staff weren't keen due to his mental state. Was argumentative with staff due to this." He was subsequently detained.

Medical note from Ward review: "remains detainable if he wants to discharge against medical advice"

As per our previously published advice, it is our view that this type of statement is not acceptable. It increases the risk of an individual's rights being overlooked such that they become "de facto" detained (detained with no legal authority and without the safeguards of the law).

This case of Mr C illustrates this. A medical note entry *"If he attempts to leave I think he is detainable and duty doctor should be contacted",* and a nursing note entry *"Remains informal at present though detainable",* were made before he repeatedly attempted to leave the ward, prior to being detained under a EDC. The nurse's power to detain was not used, and the medical note entry appears to indicate that he was 'de facto' detained prior to the EDC being granted. We return to his case later in this report.

Recommendation

NHS Boards should ensure that medical and nursing staff follow good practice when preparing individual care plans which cover the circumstances where informal individuals decide that they wish to leave.

4. Restraint of informal individuals

Key message. We found several situations where individuals were restrained and prevented from leaving hospital without proper recording and notification of the use of the nurse's power to detain. Practice must improve in this area. The 2003 Act may need to be amended to ensure that this power can be used appropriately.

Why we looked at this

Under section 299 of the 2003 Act, a registered mental health or learning disability nurse can restrain an individual who is in hospital on an informal basis and who wishes to leave. Section 299 of the Act sets out the criteria that must be met. This gives time for a medical practitioner to attend and examine the individual. We have found a very low rate of reporting of the use of this power from many hospitals.

What we expect to find

In any situation where a nurse has restrained an informal individual to prevent him/ her from leaving hospital, the nurse will comply with section 299. The nurse must record the use of this power, the time it was used and the reasons for its use. This must be done as soon as is practicable after the episode of restraint. Hospital managers must inform the Commission of this within 14 days. The NUR 1 form has been designed to make this notification. Its use is not statutory, but the notification in some form is a legal requirement.

What we found

"Nurse's power to detain" was recorded as having been used in 26 cases (16%). We saw some good practice examples of the use of the nurse's power to detain. The MWC received the required statutory notification of the use of this power in 19 of the 26 cases. In each case this was provided on a NUR 1 form. In the seven cases where we had not received notification, we asked the relevant hospital whether they had a NUR 1 form on file. This was the case on one occasion only and so there were six instances of use of this power where no NUR 1 form was completed. Failure to properly record and notify restraint could be considered an unlawful deprivation of liberty.

In addition to these 26 individuals, we found a number of additional cases where the use of this provision may have allowed examination by an AMP or where the actions of the staff were clearly of the sort governed by Section 299. We had concerns about the following cases and are taking action in relation to some of them.

Ms A is a 23 yr old lady who was admitted to an adult acute psychiatry ward with psychosis. She had been receiving care from a family member and intensive support from the Crisis Team. On admission she was in an unkempt state and did not think she was ill, but initially accepted admission. Later, quite unexpectedly, she attempted to leave forcefully. She required to be restrained by nursing staff pending medical assessment. She was then detained and transferred to the intensive

psychiatric care unit. There was no proper record of the use of the nurse's power to detain.

Mr B is a 34 yr old man who was admitted to an adult acute psychiatry ward with acute psychosis. He became more disturbed on the third day of his admission, expressed persecutory delusions, and attempted to leave the ward.

At 18:50 hrs the duty doctor documented "Over the course of the evening nursing staff have become increasingly concerned about Mr B's behaviour. Standing on tables, requiring staff to put hands on him and also return him to the ward as he had absconded." A nursing note entry at 20:00hrs recorded "Behaviour escalated at teatime. He attempted to jump on the tables. Needed to be taken down by staff. Attempting to run off the ward, refusing to return. Dropping his weight when staff trying to escort him back. Tripped up staff.......seen by duty doctor………..placed on EDC at 19:25hrs".

The duty doctor was contacted. Nurse's power to detain was not used. It seemed from nursing and medical note entries that nursing staff restrained him prior to the arrival of the doctor.

Mr C is an 18 yr man was admitted informally to an adult acute psychiatry ward with a manic episode. He became more overtly unwell after admission and was detained later that day under an EDC.

The case note entry by the admitting Doctor included "If he attempts to leave I think he is detainable and duty doctor should be contacted" (we commented on this in the previous section of this report). Nursing note entry at 19:20hrs: "Remains informal at present though detainable".

The duty doctor was contacted in the late evening and granted the EDC at 23:30 hrs. The doctor documented in the notes "…….his behaviour has been gradually escalating and has a very labile mood with episodes of aggression. He accepted 1mg lorazepam around 7pm which had minimal effect and he tried to run and escape from the ward each time he noticed the door being opened. He nearly had his feet trapped on one occasion as staff tried to shut the door quickly."

Again, there was no record of the use of the nurse's power.

We think these vignettes illustrate circumstances where use of the nurse's power to detain should have been firmly considered. It is important that, when nursing staff require to detain individuals to await assessment by a doctor, this is done with appropriate legislative authority. Failure to do so is potentially an unlawful deprivation of liberty and therefore may be a breach of article 5 of the European Convention on Human Rights. It is necessary for hospitals to ensure that individuals are not subject to 'de facto' detention, and that individuals and staff benefit from the safeguards provided by the use of the Mental Health Act.

We suspect that some nurses may misunderstand the use of the power to detain. Some may think that the form documenting the use of the power should be completed before the power is used and that any restraint to prevent the individual from leaving that they take before completing the form is performed under “common law”. This is wrong. The form is used to notify the fact that the restraint took place. We are ensuring that mental health and learning disability nurses understand this.

We found situations where the individual wished to leave immediately after interview by a medical practitioner. The following case is a good example.

Mr D is a 42 year old man who had been an inpatient in an alcohol detoxification unit for three weeks. Nursing staff contacted the duty doctor as he was wanting to leave and expressing suicidal ideas on a Tuesday evening. The duty doctor detained him under an EDC at 20:05 hrs. She documented on the EDC form that making arrangements with a view to the granting of a STDC would involve undesirable delay as “It would take too long for the MHO to attend, he would have left the ward”. She therefore could not get MHO consent to the EDC, though she consulted the MHO by phone.

The medical practitioner may have had no other option here. We have previously suggested that the Act is amended to allow for a “holding power” of two hours to be used until full assessments by a medical practitioner (preferably approved) and an MHO can be completed.

Recommendations
The making of the statutory notification to the MWC, is a legal requirement when the nurse’s power to detain has been used. Hospital managers must ensure that nursing staff comply with the law.
We repeat our recommendation previously made to the Scottish Government. A short holding power to allow full assessments by an approved medical practitioner and an MHO should be considered as part of revisions to the 2003 Act.

<u>Additional finding: Medication administered to informal individuals without consent</u>

This is a separate issue from the nurse’s power to detain. We found five cases where informal individuals were restrained and given medication by intramuscular (IM) injection against their will. In each of these cases, the incidents occurred during clear psychiatric emergency situations. We are satisfied that the treatment that was given was necessary and appropriate. The nurse’s power to detain gives no authority to treat. It was used in one of the five cases.

In four of these cases, the duty doctor was present and prescribed the IM medication. (In the fifth case, which we will mention further below, the medication had previously been prescribed). In all these cases, the doctor did not grant an EDC immediately, but waited for the MHO to attend with a view to consenting to the EDC before doing so (the longest period between administration of IM medication and the individual being detained under the EDC was 1h 45 mins).

In two of these cases the MHO felt unable to assess the individual with a view to consenting to the EDC due to the effects of the medication. In both these instances, which occurred in different NHS Board areas, the MHO advised the doctor that they should have granted an EDC without waiting for the MHO to attend. The following case is an example of our concerns.

Mr E is a 62 year old man who was admitted on a Friday to an acute adult psychiatry ward with psychosis resulting from an organic neurological disorder. The duty doctor was called to the ward to see him the following morning. Due to his psychosis, Mr E was very anxious and distressed. He was suspicious and lashing out at staff when they tried to assist him. The doctor contacted the duty Consultant. They had discussion re the prescription of psychotropic medication, including IM medication if required, management under "common law", and detention under EDC if necessary.

The duty doctor contacted a MHO who attended 50 minutes later. The clinical situation became more urgent prior to the MHO's arrival, and Mr E needed to be restrained and given intramuscular lorazepam and haloperidol. The MHO arrived fifteen minutes after this. He felt unable to consent to the EDC as Mr D had been "sedated". He agreed with staff that it would not be possible for him to assess Mr D. He discussed with the doctor his view that she had gone ahead with the detention prior to his arrival. He did not dispute the need for the EDC to be in place.

The common law "principle of necessity" only applies where there is no written statute that covers the required intervention. An EDC can be granted without MHO consent. The individual can then be given urgent medical treatment falling under the provisions of S243 of the Mental Health Act (and the responsible medical officer should notify the Commission within 7 days on a T4 form). This affords the individual and staff the protection that their treatment is authorised under the Mental Health Act, with the safeguards the Act affords. There may be some situations where the situation is too urgent for this and the principle of necessity applies. If so, there must be a clear record of the reasons for this.

The Commission's view is that it is best practice to apply an early EDC in circumstances where an individual has required to be restrained and sedated to prevent him/her from leaving hospital.

In one case the IM psychotropic medication that was given had been prescribed 18 days earlier, on admission, while the individual was informal. We consider that prescribing "if required" IM psychotropic medication for informal individuals is seldom good practice. This is because the individual is usually not consenting to receive the treatment if it is given. We think that, if a clinical situation arises where IM medication is likely to be required, urgent medical assessment should be arranged. The doctor should consider whether detention under the Mental Health Act is necessary to authorise treatment that is required, and prescribe medication as appropriate.

Recommendation
NHS Boards must ensure that medical staff act lawfully when treating individuals without consent. They should audit the use of "as required" or one-off prescriptions of psychoactive medication for informal individuals.

5. Granting an EDC.

Key message. We found gaps in availability of approved medical practitioners (AMPs) and, to a lesser extent, MHOs outside office hours. NHS Boards and Local authorities should have arrangements in place which maximise the availability of AMPs and MHOs. Medical practitioners completing EDCs must document clearly why either or both an AMP or MHO was/were not available.

Key message. We found that some medical practitioners recorded MHOs as having given consent when they had been consulted by phone but were not able to attend. Medical practitioners and MHOs need to be clear about whether or not consent is being given in this situation. The MHO's details should only be recorded on the form if it is clear that he/she is giving consent.

Why we looked at this

Our monitoring statistics show that EDC is the usual route into compulsion outside office hours. We also found that people detained after being in hospital on an informal basis were less likely to have MHO consent to their detention. We wanted to know more to help explain these findings.

What we expect to find

In circumstances where people have to be detained following a period of informal admission we expect that the reasons will be clearly stated and that the use of an EDC rather than an STDC following assessment by an AMP and MHO is necessary.

What we found

In the vast majority of cases the MWC practitioner felt that the use of the EDC was appropriate in the circumstances faced by the detaining doctor at the time, and had no doubt that management by detention in hospital under the Mental Health Act was required. However, in some cases, other factors, had they been different, might have meant that an STDC could have been arranged e.g. by the appropriate use of section 299 (nurse's power to detain), or better availability of AMPs and MHOs.

A) MHO Consent to EDC

The Act states that the consent of an MHO should be sought to the granting of an EDC unless it is impracticable.

	Yes	No	Total
"MHO Contact"	135 (83%)	28 (17%)	163
MHO Consent to EDC	87 (53%)	76 (47%)	163

When the detaining doctor attempted to contact the Social Work/MHO service through the correct channels, we recorded that there had been “MHO Contact” (whether or not an MHO was available for them to speak to). This occurred in 83% of cases. Eighty seven (64%) of those contacts resulted in an MHO consenting to the EDC. These are high rates and indicate good practice and good responsiveness of MHO services in many instances.

There were a number of cases (of the 135) where the doctor who issued the EDC could not contact an MHO. In some of these cases it was clearly documented that there was actually no MHO on duty. Most were outside office hours. We are concerned that there remain gaps in MHO cover out of hours in some areas.

“Attempted to contact duty MHO – not available currently (due to rota gap)”.
(EDC granted Tuesday, 20:55hrs).

“There was no MHO on duty” (EDC granted Tuesday, 1930hrs)

(A man in hospital in the neighbouring local authority area to his home area). "Hospital locality SW would not contact MHO as he is nearby town’s patient. Neighbouring local authority did not have MHO available until after 9pm therefore not enough time." (EDC granted Sunday, 14:20hrs)

“The MHO is not available until morning” (Doctor had contacted SW Dept, EDC granted Friday, 23.45hrs).

“No MHO currently on call” (EDC granted Sunday, 19:30hrs)

MHO said they were not available at the time but would be the following day. Patient was placed on STD the following day. (MWC Practitioner). (EDC granted Saturday, 16:45 hrs).

“Social Work department contacted. No MHO available until tomorrow morning” (EDC granted Friday, 19:40hrs)

"No MHO was available due to a combination of local holidays and industrial action". (EDC granted Wednesday 15:45hrs).

One case involved the handover period between the duty service and the area team.

“I discussed the case with the duty *MHO who stated that she could not come to assess as her shift was ending in 10 minutes. Waiting for a local MHO would have resulted in an undesirable delay given the urgency of the situation”.*
(EDC granted Tuesday, 0830hrs)

In a number of cases we could not tell from the hospital notes, or the content of the EDC form, whether or not the MHO attended and assessed the individual prior to consenting to the EDC. We think that this should be clearly documented both on the EDC form and in the hospital case notes.

There were four cases where it seemed from the EDC, and the reports completed by MWC practitioners, that the detaining doctor received MHO consent over the phone, without the MHO seeing the individual prior to the granting of the EDC.

Doctor noted on file that they spoke to the MHO by phone. MHO could not attend immediately but it was the same MHO who consented to the first EDC 4 days before -she knew the case and was prepared to consent over the phone given the circumstances as described by the doctor. Doctor wrote in file. "Discussed with the MHO via phone. She agreed with above (i.e. that criteria for detention met) but is unable to attend. She had recent previous involvement with the case." Individual was reviewed the following day and an STDC was granted then. (MWC Practitioner)

The above is clearly an example of appropriate practice. MHOs should remain familiar with the guidance in the Code of Practice re consenting to an EDC over the phone, including the exceptional circumstances when this is appropriate, and that they or another MHO should attempt to see the individual as soon as is practicably possible after the EDC has been granted.

In the other three cases, the doctor's entries on page 4 of the EDC were ambiguous for the following reason:

- The doctor entered the MHO's details in Box A, under the statement "I have consulted the MHO named below, and he/she consents to the granting of this emergency detention certificate".
- They also wrote text in Box B under the statement "It was not practicable, for the reasons stated below, to gain the consent of an MHO to the granting of this certificate."

The statements in Box B of the EDC in the three cases were:

"MHO consulted by telephone. Detention expedited in MHO absence to avoid further delay in treatment".

"I contacted the duty MHO, but as I had to apply the emergency detention sooner, there was no chance for her to come in. Her name is X. She agrees to my plan."

"MHO unable to attend tonight but agrees that detention is required in this case. Discussed with her on the phone."

The doctor should make it absolutely clear on the EDC form whether or not the MHO consented to the EDC. We recommend that, where the MHO cannot attend and has discussion with the doctor, they make it particularly clear whether or not they are giving consent to the EDC, and discuss with the doctor what they intend to record regarding this on the form.

Medical staff should provide clear explanations on EDC forms when it is not practicable to gain the consent of an MHO to the granting of the EDC. In 28 cases (17%), we recorded that the doctor did not make contact with the MHO. In the vast majority of cases this was due to the clinical urgency of the situation and clearly appropriate given that, at present, there is no other legal option.

AMP availability

In a large number of cases in various health board areas, AMPs were not available to assess the individual with a view to the granting of a STDC. This was particularly the case outside normal working hours. In some cases this was clear from entries on the EDC form. In some areas Commission visitors were told by nursing staff that on call AMPs do not normally attend to assess individuals out of hours with a view to the granting of a STDC.

We selected 32 cases where AMP availability was a clear issue and looked to see if an MHO gave consent to these EDCs. MHO consent was gained in 28 of those cases (and this was only given over the phone in one of these cases, to our knowledge).

Some extracts from entries made by the detaining doctor on EDC forms as the explanation why making arrangements with a view to the granting of a STDC would involve undesirable delay (where MHO consent was obtained in these cases, this was not over the phone, to our knowledge):

"Due to the unavailability of senior consultant psychiatrist as it is in the out of hours time period, STDC could not be possible at this time." (EDC granted Friday, 20:30hrs, MHO consent)

"Need for a RMO, none available tonight and will be reviewed first thing in the morning." (EDC granted Tuesday, 23:30hrs, MHO consent)

"Out of hours nature of situation" (was all that was written in this section on the EDC form). (EDC granted Sunday, 18:00hrs, MHO consent)

"There is no AMP as this happened at a period that is outside normal working hours. There is no MHO available at this time, no MHO on duty."(EDC granted Tuesday, 19:30hrs)

"Out of hours nature of situation makes a STDC unable to be granted." (EDC granted Saturday, 18:00hrs, MHO consent)

"Out of hours", "Not willing to remain in hospital". (EDC granted Tuesday, 21:25hrs, MHO consent)

“No consultant psychiatrist available for STDC” (EDC granted Sunday, 15:15hrs, MHO consent).

It appears to be common for AMPs not to be available outside normal working hours to conduct assessments with a view to the granting of a STDC. We are concerned by this. Significant numbers of individuals are not being afforded the safeguards of assessment by an AMP and the granting of a STDC, if the grounds for detention in hospital are met. We consider that NHS Boards should review arrangements for AMP availability outside normal working hours.

There were many EDC forms where we thought the explanation entered for why making arrangements with a view to the granting of a STDC would involve undesirable delay was not clear. This was because timescales before an AMP assessment could be arranged, or reasons why an AMP was not available, were not adequately documented. In some cases there was no mention of consideration being given to contacting an AMP at all. In a number of these cases ward staff told the Commission practitioner that an AMP would not have been available as the EDC was granted outside normal working hours.

It is important that doctors adequately document on the EDC form why the grounds for the granting of the EDC were met. This must include reasons why it was not practicable for them to arrange for an AMP to assess the individual with a view to the granting of a STDC.

Also, in a few cases we also saw no entry in the medical notes regarding the granting of the EDC. The detaining doctor must record the granting of an EDC in the case notes as well as on the form.

Police involvement

Police involvement was noted in 23% of cases. They were involved in a variety of ways, e.g. by bringing people to the hospital for assessment or returning people to hospital if they had left the ward against advice. It was clear that police input had been very helpful in many of these cases, and we saw examples of good practice.

Police involved in original admission, but not EDC. He was very happy with how police treated him, they took him to A&E for psychiatric assessment.

Was admitted to the hospital via the police station as had been taken into custody for threatening care staff at supported accommodation with a knife. Had agreed to admission as he felt he could not cope at home at present. Is well known to learning disability services and responsible medical officer spoke to doctor doing assessment to give background. Wanted to leave and was detained under EDC. Reviewed by LD Consultant and put onto STDC.

Was very psychotic, with fixed delusions about pregnancy, forced abortion, misidentifying staff and fearful, overactive, irritable, hostile. Had twice left hospital, seen as very vulnerable, risk included risk of provoking assault. Returned voluntarily with police, but was then unwilling to stay, no insight into her current relapse.

The role of police in returning informal individuals to the ward was highlighted by a number of cases. However, it is not clear under what authority this is carried out as the use of section 297 would not seem to be appropriate where the person is already a patient in hospital as it was intended to provide for people who were not currently receiving care and treatment in hospital. It also does not cover removing people from their homes or facilitating the admission of a person from the community under either an EDC or STDC.

Urgent medical treatment under S243 of the Mental Health Act

Key message. Responsible medical officers have a statutory duty to report the giving of urgent medical treatment to individuals subject to emergency detention. We found some instances where there was no record of this notification.

We noted in a few cases that individuals had received IM psychotropic medication as urgent medical treatment while subject to EDCs, and the Commission had not received notification of treatment under S243 of the Mental Health Act. This failure to comply with the law is potentially a breach of the individual's human rights.

Medical and nursing staff need to be clear that an EDC is not a treatment order. It confers no authority to give medication that the individual does not consent to receive unless this is urgent medical treatment given within the provisions of S243 of the Act. When such treatment is given, the RMO is required to notify the MWC within 7 days (this should be done on a T4 form).

Recommendations

NHS Boards and local authorities should take note of the findings of this report. We would like to see action plans that address:

- Better round-the-clock availability of AMPs and MHOs (especially the former);
- Clear instructions to medical practitioners and MHOs on what constitutes consent and how to document it;
- Local audits of urgent medication administered under EDC to ensure proper reporting to the Commission.

6. Reviewing an EDC

Key message: We found significant delays before individuals subject to an EDC were reviewed by an AMP, especially if admitted at the weekend. NHS Boards should ensure early reviews by an AMP in order to revoke an EDC if the criteria are no longer met.

Why we looked at this

In our annual monitoring reports, we comment on the duration of EDCs. We have been encouraging NHS Boards to ensure the earliest possible review of individuals subject to EDCs. We expect that this will usually result in the granting of an STDC or the revocation of an EDC.

What we looked at

We examined the case records of all individuals in our sample to determine the length of time between the granting of an EDC to the point at which it was revoked or superseded.

What we found:

Of the 163 EDCs for individuals whose cases we examined

- 97were placed on a subsequent order (STDC except for one individual for whom an interim CTO was granted),
- 35 were actively revoked
- 31 were "allowed to lapse" at 72 hours

	When EDC granted		
Post-EDC……..	**weekday**	**weekend**	**X-Mas/New**
STDC	62	32	2
Interim CTO on Day 3	1		
Revoked	21	12	2
EDC Expired	21	9	1
Total	**105**	**53**	**5**

Nineteen percent would appear to have either not been seen by an AMP or the decision taken to let the EDC run its full course

We looked at the day on which the EDC was revoked or superseded. Counting the day on which it was granted as "day 1", the day it ended could be up to "day 4".

We were interested to find out whether the EDC period tends to be longer for people who are detained during a weekend or public holiday compared to those who are detained during normal working hours.

We divided the 163 individuals into two groups –

(1) Those for whom where there was one calendar day or less between the time the EDC was granted and the beginning of the next normal working day (113 people).

(2) Those for whom there was more than one calendar day between the time of granting of the EDC and the beginning of the next working day (50 people).

	≤1 calendar day between EDC and next working day	**>1 calendar day between EDC and next working day**	
Day on which EDC ended	Number	%	Number
Day 1	16	14%	5
Day 2	44	39%	15
Day 3	28	25%	8
Day 4	25	22%	22
Total	**113**	**100%**	**50**

As can be seen, people for whom there was more than one calendar day between the time of granting of the EDC and the beginning of the next working day tended to wait longer for their EDC to end. It seems likely that this is happening because of lower availability of AMPs, and in some cases MHOs, to review people subject to EDCs outside normal working hours. We appreciate, however, that some individuals will have been reviewed by AMPs or MHOs without this resulting in their EDC being revoked or superseded by a STDC. This is not reflected in the above exercise.

A more detailed breakdown of what happened after an EDC was granted in shown in appendix 3.

The higher availability of AMPs and MHOs during normal working hours is further indicated by figures for the granting of STDCs (see Appendix A). For the period 1/7/11 to 29/2/12, there were 2277 STDCs granted. 91% of these were granted on weekdays, and 9% on Saturdays or Sundays.

We are concerned that individuals detained on EDCs on weekend days, or days affected by subsequent public holidays, appear to be being disadvantaged. There is a tendency for it to take longer for their EDC to be reviewed by an AMP and MHO, and for them to benefit from the safeguards of these assessments and the granting of a STDC, should that be indicated. We do not think this is acceptable.

Recommendations

NHS Boards and local authorities should endeavour to ensure AMP and MHO assessments of any individual admitted under an EDC as soon as practicable after admission. In our view, this should take place within 24 hours of admission.

The Scottish Government should consider shortening the period of emergency detention to 24 hours where there is no MHO consent.

Conclusions and further action

Detaining individuals who had initially agreed to be admitted informally can be a cause of distress. In the process of deciding whether or not this step is necessary, there is a risk that individuals' right to liberty is breached unlawfully. We have identified several actions in this report to improve practice and reduce the likelihood of unlawful detention.

We have also made several recommendations about better completion of certificates and better availability of specialist practitioners to examine the need for detention. Even with these actions, we consider that the 2003 Act should be amended to provide for shorter periods of detention without both an AMP and MHO being involved.

Our concern about de facto detention and possibly unlawful restraint of informal individuals is so great that we are likely to repeat this exercise again in the near future.

Appendix A

(Reproduced from the MWC's monitoring Report "Short Term Detention", March 2010)

<u>'De facto' detention –</u>

Where individuals meet the criteria for compulsory treatment in hospital they should be given the full safeguards provided by treatment under the 2003 Act. During our visits to people on short term detention we occasionally noted that staff have written "detainable if wishes to leave" or similar, in an individual's notes. In the worst cases, notes did not even identify whose decision this was, when it was to be reviewed, or whether it has been discussed with the individual.

Even with these details, it is our view that this type of statement is not acceptable. It increases the risk of an individual's rights being overlooked such that they become "de facto" detained (detained with no legal authority and without the safeguards of the law). If the RMO considers that compulsion may not be necessary and wishes to avoid continued use of the mental health act, but is still concerned that the individual may not always comply, then a written plan should be in place detailing what should happen if the individual expresses the wish to leave the ward. It may then be appropriate to record a statement in the notes such as:

"Requires to be reassessed if wishes to leave. Use of nurses holding power may be required".

This statement should be explained to the individual and, where appropriate, to his or her advocate. If the individual is unhappy with this situation, consideration should be given to whether their status as an informal individual accurately reflects their needs. If possible, the RMO should document his or her assessment of the grounds for detention at that time.

Unless an appropriately qualified nurse feels that the individual meets the criteria for the use of the nurse's power to detain, an informal individual who wishes to leave the ward has that right. We will continue to review this aspect of patient care on future visits.

Appendix B

STDCs

1.4.11 - 31.3.12 STDCs		
	Total STDCs	**%**
Day of week		
Mon	545	16%
Tues	574	17%
Wed	597	17%
Thurs	623	18%
Fri	795	23%
Sat	179	5%
Sun	140	4%
Grand Total	**3453**	

1.4.11 - 31.3.12 STDCs		
	Total STDCs	**%**
Weekday	3134	91%
Weekend	319	9%
Grand Total	**3453**	

1.7.11 - 29.2.12 STDCs		
	Total STDCs	**%**
Day of week		
Mon	359	16%
Tues	380	17%
Wed	399	18%
Thurs	407	18%
Fri	526	23%
Sat	113	5%
Sun	93	4%
Grand Total	**2277**	

1.7.11 - 31.3.12 STDCs		
	Total STDCs	**%**
Weekday	2071	91%
Weekend	206	9%
Grand Total	**2277**	

Appendix C. More detailed breakdown of what happened after an EDC

Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE
Tel: 0131 313 8777
Fax: 0131 313 8778
Service user and carer
freephone: 0800 389 6809
enquiries@mwcscot.org.uk
www.mwcscot.org.uk