

## JISC update June – July 2016

### Security in the ED

An East London service asks: we are looking at improving how we work with security in the ED to prevent high-risk patients absconding (usually whilst awaiting MHAA or transport). We have a number of ideas/plans, but would really like to hear examples of good practice elsewhere, and anything you have successfully implemented to keep patients safe in the department with the help of security staff.

**Response one – North London:** My view is that we need a legal opinion on the authority for preventing a patient leaving the ED if there is no medical problem (i.e. the MCA does not apply). *Following Sessay the authority to restrict movements appears to rest on the fact that a MHA is “in process” but we know from Sessay that detaining someone for 13h pending MHA amounted to false imprisonment, so, is there a time cut-off at which we should simply release people? When does the clock start – from the time of arrival in ED or from the time of first expressing objection?*

Once MHA application has been made and patient is awaiting transport, then there is clear legal authority to detain and convey to hospital, indeed failing to detain someone in these circumstances is an act of **negligence – relevant case is [Webley v St George’s](#)**

#### Response two - Exeter:

This team have done a lot of training already and have a plan to do more joined up delivery of “managing distress” and “de-escalation” with themselves and acute and security staff. CQC requirements have made the acute hospital more aware of its lack of suitable training for staff around delirium, restraint, rapid tranquilisation etc on the main wards predominately. They do have good relationships with the acute hospitals security; but they are not for the ED department alone and can often be called away- leaving a choice between allowing patients to leave or trying to keep an eye on them whilst they wait for assessment under the MHA. They often ask the police to pick people up that they have not safely managed to keep in the ED and request they take them on a 136 to the health based POS for safer management but, as they are under huge pressure to reduce their 136 numbers, they often simply bring them back to ED having informally and then leave. Security are reluctant to use any physical restraint if the patient is not detained (and thus they are often not) and so we can only document a lack of capacity to make safe decisions around their health needs and recommend they are not allowed to leave before a full assessment under MHA. ‘These are pragmatic solutions, not ideal, and whilst training is helpful the legal situation is the crux of it in my view.’

**Response three:** ‘I am rather slowly catching up with the Sessay judgement where a 13 hour detention was deemed unlawful. That’s perhaps not a surprise but some of the other statements are. For those of you who haven’t memorised it – [Sessay Judgement](#)

The Court gave six reasons for its decision (paragraphs 35-40):-

1. Part II MHA 1983, taken together with ss135-6 MHA 1983, sets out a procedure for the compulsory admission of patients;
2. Parliament had expressly provided in s4 MHA 1983 for applications of urgent necessity;
3. The Code of Practice provides guidance in relation to s4 MHA 1983 admissions;
4. The Defendant’s own policy provided for urgent admissions to be by way of s4 MHA 1983;
5. If a patient tries to leave before completion of a s4 MHA 1983 application, the hospital can contact the police to use their powers under s136 MHA 1983. For these purposes, the A&E department of a hospital is a “place to which the public have access”;
6. Approving *B v Forsey* [1988] SLT 572, HL, the powers available to hospitals under MHA 1983 may not be supplemented by reliance on the common law. Citing Lord Keith: “These provisions display a coherent scheme for the admission into hospital and detention there of mentally disordered persons..... any common law power of detention which a hospital authority might otherwise have possessed has been impliedly removed.”

I was very surprised by their finding that there is “no lacuna in mental health law”. I had always said that there were common law powers, but this is explicitly denied in point 6. **They advocate S4 and if that’s too slow then call the police who will do a S136 in A&E.’**

East London replies to the three respondents: ‘We have indeed many times called police to perform a section 136 in the department, with varying but improving degrees of success. Our police liaison officer and I have done some work in trying to improve local police understanding of the law and we get fewer instances of police telling us that we can’t use 136 in ED because it’s a place of safety. Although we have our hiccups I do appreciate from this thread and from colleagues in other areas that we are probably unusually lucky here.’

Back to 'common law' and powers of detention whilst you're waiting for a MHAA, though, there is a further statement in the Sessay judgement which is important':

"In our judgment Parliament provided an exhaustive code concerning compulsory admission to hospital in Part II MHA. Sections 2-6 cover procedure for hospital admission which include in s.4 admission in emergency situations. We do not accept that there is any lacuna in MHA in relation to the period when a person is at the hospital pending an application under s.2 or s.4 MHA. **Each case necessarily turns on its own facts. However, in our view it is unlikely in the ordinary case that there will be a false imprisonment at common law or deprivation of liberty for the purposes of Article 5(1) ECHR if there is no undue delay during the processing of an application under ss.2 or 4 MHA for admission.**"

'So each situation will be judged on its own merits and there may be circumstances which could not have been foreseen which were so immediately serious that intervention was necessary before the MHA could be applied. The patient may well have grounds for legal challenge but the court would be unlikely to apportion any blame. I think the decision at this point comes down to immediacy and severity of perceived risk. However there is no indication as to what the time cut-off might be for considering something an "undue delay".

I think the Rabone case is probably relevant here - remember the MH trust in that case was found to have breached her right to life because she killed herself on leave as an informal patient, but there was not seen to be a distinction between informal and detained patients. Despite having no legal grounds to stop an informal patient having leave (or in our case, leaving ED), we are still considered to have a duty to protect life. It's not very clear how we do that in every case given different bits of case law can seem to contradict each other.

### Back to North London:

'Is anyone interested in doing a multi-site audit with a view to publishing in this area? I have a protocol which can be shared on the duration between arrival in ED and MHA assessment being concluded. Locally we found about 1/3 of MHA assessments were completed >12h after the patient first attended the emergency department – if this could be highlighted/published as an issue occurring across England & Wales then it might result in some attention and some change.'

**York's response:** 'I would be interested in participating in this, we have huge delays in MHA assessments being concluded and the patient then being transported out of the department even once this has been completed' –it would be good to highlight these issues.

**Newcastle and Bristol Liaison response:** happy to be involved in multi-site audit.

**Kings:** We have similar discussions here at King's with ED and security about the difficulty in having an awareness of Webley (not to be negligent); but also not falling foul of the Sessay time limit (not to be falsely imprisoning). We do, on occasion, get police to put people on a S136 in the ED - but this is usually only in situations of extreme disturbance and violence to person and property. We 'would be interested in getting involved in highlighting this issue more widely and auditing what happens locally to add to the national picture'.

**Oxford:** Sessay was interesting as it was the unusual circumstances in which s5 MCA was used to detain someone in the Maudsley's s136 suite, not the ED. We use the MCA all the time in the ED, and often while awaiting MHA assessment and I think this is a different situation to being on a mental health unit (such as a s136 suite). The current DOLS case-law is so contradictory and the likelihood of being taken to court so low, that I am perfectly happy to be pragmatic in the use of the MCA in ED's. This clinician used to be a barrister!

### Oxford is back

Dear colleagues

We will be shortly advertising **substantive consultant posts** in the psychological medicine service of this leading acute trust. We will be seeking to appoint at least 2 posts. The appointees will join a team of 10 consultants and 3 trainees providing truly integrated medical and psychiatric care for in and out patients. The posts will comprise sessions in the trust wide emergency service and sessions working as a member of a medical team in one of the specialities we are joining – precise job plan to be negotiated but these include: Regional trauma centre, Cardiology, Haematology, ITU, Primary care, Neuro rehab, Research and teaching

**St Marys** is also expanding – PT consultant post.

## Think Kidneys

This clinician has been psychiatry lead on the 'Think Kidneys' campaign, which is part of an NHS campaign to improve the care of people at risk of, or with, acute kidney injury. Within psychiatry, we obviously look after a group of patients with a high risk of poor physical health outcomes, and higher overall mortality rates, making this very relevant for our patient group. In collaboration with the Think Kidneys campaign, as part of a working group, we have developed new guidance for the management of patients at risk of, or with AKI in a mental health setting. This guidance was recently published and can be accessed at [Think kidneys](#)

## BREXIT blues?

North London reports a case of Dissociative Weakness in response to the Brexit.  
Have others come across any Brexit-related mental health presentations?

Responses:

1. I was reading the Evening Standard over someone's shoulder on the tube on the way home this evening, and saw an article on a spike in private psychiatry consultations in response to the trauma of Brexit. Perhaps we could get together a case series for the BMJ.
2. 'Just been at a conservative MP dinner. They heard the same. These were all Remain I should say'
3. 'What Exit?'

## CFS

Are there any inpatient units in the UK which could help someone with severe ME/CFS where there are associated illness belief issues?  
Any suggestions appreciated.

### Responses below:

See [Find Hope](#)

Hughlings Jackson ward at **Queen Square** is a possible service, but they have a long waiting list (Contact [Eileen Joyce](#)).

Also some CFS services also run domiciliary services for severely affected patients.

Two other units may be of interest:

**[Burrwood Hospital, Kent:](#)**

**[St Cyril's Hospital, Chester:](#)**

Also Professor Lynne Turner-Stokes at **St Georges Hospital** occasionally accepts people with functional neurological disorders at the Regional Rehabilitation Unit (which usually sees people with brain injuries and mobility/speech problems).

**Leeds Unit response:** the Yorkshire Centre for Psychological Medicine is to provide a specialist biopsychosocial inpatient service for people with severe and complex CFS/ME. It's an 8 bed ward in the general hospital and a multidisciplinary team which includes physiotherapy and OT as well as medical (LP), nursing, pharmacy, dietetics, etc There is access to any and all medical/surgical specialities, but perhaps more importantly the ability to deliver physical and occupational rehab, alongside psychotherapeutic interventions as indicated by the assessment/formulation, treating any comorbid MH aspects, and addressing the iatrogenic elements which are generally present by the time someone is at this level of severity of their condition. The latter might be what they have been told (or have heard) about their illness, as well as sometimes quite extreme amounts of medication, plus maybe tube feeding, suprapubic catheters, etc. Also of course managing/addressing the physical effects of their reduced (or absent) mobility, and dealing with sensitivities to light and sound... all of this together and at the same time. The approach is, necessarily, very much tailored to the individual (a pre-set programme doesn't work in the really severe cases), but we have a lot of experience now in delivering treatment in an effective way and helping people towards recovery. The aim is often to get to the point of transferring ongoing care back to the relevant local teams, but after having reached the point at which those teams can now access (in clinics) and work with the person concerned, in order to continue on the new trajectory and in ways which had not been possible before. There is some additional background information on our Trust webpage, easy to find by googling "YCPM".

Important to note that we take patients from anywhere in the UK and, since we opened the doors to national referrals 7 years ago, have had numerous admissions from all over the country, Cornwall to the Highlands. Good outcomes, in people who quite often have previously been considered untreatable.

Having said all of that general stuff, Professor Peter White's point about the case in question is well made. That is, issues around the patient's beliefs. The word of caution would be to make sure to explore and clarify the

nature of those beliefs. The content is obviously around physical illness, and possible pathogens / aetiology, but the form of the beliefs might cross the line into a delusional area, with implications of that for deciding upon appropriate treatment. If frankly delusional/psychotic we would tend to advise local teams to focus on appropriately assertive treatment for that. If not, i.e. more generally severe and complex CFS/ME but with some particular thoughts and theories about how it started, that would potentially be fine to come to Leeds.

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Worthing