Does a Full Moon or Super Moon Have An Influence on Humans and Animals?

By Dr Mohammed Shaffiullha (ST6), Dr Mohammed Ismail (ST6), Dr Nusrath Ali Baig (Staff Grade)

Historically, the colloquial term lunatic was used to describe an individual who was experiencing mental ill-health or displaying menacing, unreasonable or erratic behaviour, symptoms, which in the past, were labelled as being in a state of lunacy. Originally derived from the word Luna, the ancient Roman Goddess personifying the Moon, or the Latin version lunaticus, it denotes being moonstruck or under the Moon’s influence. While generally regarded as politically incorrect nowadays, nevertheless, the term lunatic can occasionally still be used in a flippant manner. Being depicted in this way intimated that the individual was affected by periodic episodes of mental illness, previously considered to be connected with the different lunar phases.

A long-established belief was that the full moon had a negative impact upon mental health. One popular misconception was the strong association between the full moon and an increase in suicide rates, as well as epileptic seizures. However, no robust evidence base exists to substantiate these claims. Nevertheless, the Moon does appear to exert a strong gravitational force which controls the tides. In addition, the light it emits is believed to influence ancient animal behaviour, for example, coral mass spawning has been found to occur after a full moon (Riley, 2016).

Initially, being classified as a lunatic predominately included those diagnosed with epilepsy and experiencing mental ill-health conditions (Riva et al., 2011). However, during the time period from 300–500 AD, astrologists extended the term to encompass those with neurological and other broader mental disorders. By the end of the 19th century, other language had been introduced to describe legal insanity, of which the most commonly used was non compos mentis or not of a sound mind.

Aristotle, the ancient Greek philosopher, advanced the theory that people with a bipolar disorder were more likely to be negatively impacted by the full moon. He attributed this to sleep deprivation, as a result of additional light being emitted during this lunar phase, leading to greater illumination at night. Research undertaken by Drum, Terry and Hammond (1986), demonstrated that people with schizophrenia were 1.8% more likely to exhibit hostile and belligerent behaviour around the time of a full moon. However, subsequent analysis by Owen et al. (1998) failed to establish this association in people who did not have a diagnosis of schizophrenia. A re-analysis of mental health and quality of life research data, carried out by Barr (2000), revealed a significant change during a full moon, however, this was only discernable in those with schizophrenia. Therefore, caution needs to be exercised in the interpretation of these findings, as these behaviours cannot definitively be linked to lunar influences.

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(...continued from page 1)

Rotton and Kelly (1985) conducted a meta-analysis, involving a total of thirty-seven studies, in order to ascertain if an association existed between the four moon phases and various mental illness-related activities. None was found to occur. While almost two-thirds (23/37 i.e. 62%) of the studies did initially assert that a relationship existed, this was subsequently undermined by the appearance of one or more statistical errors in almost 50% of these publications. Accordingly, they concluded that lunar phases were not related to an increase in in-patient admissions to mental health facilities, murders, car accidents, suicide and other criminal activities. On closer examination of the specific research where a correlation had first been shown to occur, invariably other factors were identified which could have influenced these behaviours. Some examples include where the full moon appeared simultaneously around the time of other significant events, such as holidays or the weekend, typically characterised as disruptive periods. Furthermore, in the majority of cases, no association was found to occur in an examination of twenty studies exploring the link between the moon phase and suicide (Kelly, Rotton and Culver, 1996). Similar to other studies, these authors did not take other factors into consideration, such as disparities relating to the day of the week in which the incidents occurred. Inconsistencies emerged in the few cases where a positive relationship was recorded. A further study by Margot (2015) also failed to establish a link between human behaviour and the various phases of the moon and also reported that there was no co-relation between hospital re-admission or birth rates and lunar effect. The author further concluded that the studies linking lunar effect on human affairs had methodological flaws.

Few of the researchers have found that majority of epileptic seizures occurred during the moon’s last quarter with the least number of cases presenting during the full moon phase. Research subsequently undertaken by Baxendale and Fisher (2008) revealed that a significant negative association occurred between the average number of seizures and the proportion of the Moon illuminated by the Sun. However, when clearness of the night sky was controlled for, this relationship was no longer apparent. This would appear to indicate that it is the brightness of the sky, coupled with the nocturnal luminance, as opposed to the lunar phase per se which may impact upon the incidence of epilepsy seizures.

**Discussion**

The myth is often perpetuated that the full moon induces labour in pregnant women, or alternatively can arouse agitated behaviour amongst nursing home residents. Ancient philosophers held the belief that the Moon directly impacted upon both human health and behaviour, as a result of gravitational body fluid pressure. However, more recently, specialists involved in this field have continuously dispelled such myths, as well as any other associated lunar effects. Therefore, this raises the question as to why do these fallacies continue to prevail in the absence of any evidence base to substantiate such claims? This could be attributed to confirmation bias or selective recall, whereby people tend to observe or retain information which aligns with or confirms their individual preexisting views or hypotheses. They subsequently associate this information with specific events, for example, linking it with a busy time in their lives. Conversely, when a crescent moon appears in the sky, they are less liable to form an association or even attend to it, in the first instance. Multiple potential external factors also influence this behaviour, in particular the role Hollywood plays. Numerous films synonymous with the horror genre typically depict nights where a full moon appears as occasions where sinister events such as stabbings, shootings and psychotic disturbances are more likely to take place.

A further question remains as to how have these notions become so deeply ingrained in our psyche, in the first instance? One interesting theory has been advanced which proposes that prior to the widespread installation of outdoor lighting, homeless people may have been more vulnerable to mental ill-health and seizures. This has been attributed to their lack of sleep as a result of the excessive illumination emitted during the full moon. Alternatively, others have claimed that the full moon only exerts an influence upon some specific individuals. Therefore, inevitably research which adopts a general population-based approach will frequently be unable to identify any discernible impact.

The possibility still exists that exploring the full moon from new perspectives could demonstrate that, in reality; it has the power to expose the primitive and instinctual nature in some cohorts within the plant and animal community.

**References**


Dr M. Shaffiullha & Dr Nusrath Baig, Birmingham and Solihull Mental health Foundation trust. Dr M. Ismail, North West London NHS foundation Trust
Introduction
Bipolar disorder is a potentially lifelong and disabling condition characterised by episodes of mania or hypomania and episodes of depressed mood (1). This mental disorder can cause functional impairment and emotional distress for the patient and can have an effect on the carers involved (2). As mood disorders often reoccur and have poor long term prognosis, there is high emphasis on acute and maintenance treatment (3).

For guidance of clinicians, NICE published CG185 in September 2014 for assessment and management of Bipolar disorder in younger patients, adults and elderly patients which was updated in February 2016. For the purpose of this audit, NICE Guidance for management of Bipolar Disorder in adult patients was studied.

Aims
To review our clinical practice in the management of Bipolar Disorder in adult mental health patients by looking at the quality of documentation in clinical notes and comparing it with NICE Guidance (CG185, February 2016).

Method
Case notes of 20 patients (N) newly diagnosed with Bipolar Disorder in 2015 and 2016 from Hallam Street Hospital were audited retrospectively.

Data was collected from documentations during the inpatient episode (admission notes, ward round entries and discharge summary) and outpatient clinic letters.

An audit tool was designed to collect data on demographics, treatment pathway followed, physical assessments carried out and documentation of information given to patient and family.

Results
The sample consisted of 60% females and 40% males with mean age of 39, the youngest patient was 23 and oldest 63 at time of diagnosis. 40% patients were diagnosed with Bipolar Disorder between the age of 36 to 45 years. Employment status was documented in 60% of sample with only 10% being in employment currently. Marital status was documented in 90% with 35% of sample in relationship.

Our clinical practice is in accordance to NICE guidance in following the pathway for treating manic/hypomanic and depressive episodes (95% started on anti-psychotics; 70% according to NICE and 5% on mood stabiliser). Eighty four percent of patients were maintained on anti-psychotics and 40% on Valproate. Surprisingly none of the patients in the sample was maintained on Lithium.

Compliance with investigations requested at the time of admission was 40-65% and annual monitoring of the physical health of patients requested is 78%.

Fig 1: Evidence of documentation of information given N= 20

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<tr>
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<tr>
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Fig 2: Treatment pathway followed in hypomanic/manic episode N1=17

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<tr>
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<tr>
<td>Commenced on anti-psychotic</td>
<td>16</td>
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<td>Lamotrigine restarted</td>
<td>1</td>
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Fig 3: Treatment pathway followed in Depressive episode N2=3

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<tr>
<td>Fluoxetine</td>
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</tr>
<tr>
<td>Quetiapine</td>
<td>3</td>
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<tr>
<td>Lithium dose increase</td>
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Fig 4: Maintenance therapy in 60% of the sample followed up in outpatient clinic N3=12

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</tr>
<tr>
<td>Aripiprazole-1</td>
<td>8%</td>
</tr>
<tr>
<td>Quetiapine-1</td>
<td>8%</td>
</tr>
<tr>
<td>Olanzapine-2</td>
<td>16%</td>
</tr>
<tr>
<td>Paliperidone depot-1</td>
<td>8%</td>
</tr>
<tr>
<td>Haloperidol Depot-1</td>
<td>8%</td>
</tr>
<tr>
<td>Valproate</td>
<td>2</td>
</tr>
<tr>
<td>Valp+Quetiapine</td>
<td>2</td>
</tr>
<tr>
<td>Valp+Olanz</td>
<td>1</td>
</tr>
<tr>
<td>Aripip+Lamotrigine</td>
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Abstract

Diogenes syndrome is also commonly known as senile squalor syndrome. The name Diogenes is derived from the name of an ancient Greek philosopher Diogenes, who rejected worldly comforts and lived a life of shabbiness and squalor. Diogenes syndrome is a disorder where the person, usually elderly, has a tendency to retreat into solitary confinement, collect and hoard objects. They tend to have difficulty with maintaining their personal hygiene and cleanliness of their surroundings. They have little insight into their condition and they have significant difficulty with activities of daily living. An extension of this disorder is called Noah syndrome, aptly described as a disorder where the individual starts to hoard various types of animals, such as pets. It is characterized by poor insight into the living conditions: extreme clutter, lack of sanitation, several different types of animals, usually cats and dogs that can be malnourished and in poor physical health. The syndrome can be associated with other comorbid psychiatric conditions like Depression and Dementia.

Clinical Manifestations

Senile squalor syndrome or Diogenes syndrome is becoming an increasingly common condition in the elderly. Noah syndrome being a variant of Diogenes syndrome has many characteristics in common with the disorder. It is characterized by extreme hoarding behaviour, denial of the need for external intervention and social norms, social withdrawal and a resistance to change. The individual is usually an elderly female, single and most commonly living alone with above-average intelligence.

Individuals who are never married are at increased risk of excessive hoarding, resistance to a change or introduction of a treatment regime. They are at increased risk of physical and mental health morbidity and mortality. The person may hoard stray animals from the streets or may register with animal charities that may deliver animals unknowingly to the affected individual. Animal numbers might increase due to uncontrolled reproduction. The hoarding behaviour usually stems from increased loneliness and a need for a reciprocal relationship. It can reach to the heights of inappropriate altruism and selflessness. The person has no insight with regards to the physical needs of themselves or the animals living with them. The living conditions are usually in a dilapidated state with animal faeces, insect infestation and piles of rubbish. The individual and animals are usually malnourished and in poor physical health. There have been accounts of animal cruelty. Hoarding can pose a serious public health threat due to insects and rodents infestation.

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The individual usually comes to attention of health authorities when they are due for mandatory checks or brought in by emergency services after physical health breakdown. In many cases, several years may lapse before they come to the attention of psychiatric services. There is a predilection of the condition in patients with dementia as shown by various studies. Patients are shown to have marked frontal lobe deficits as the frontal lobe is involved in higher order functioning such as reasoning, judgement and decision-making. Other psychiatric conditions associated with hoarding include OCD, bipolar disorder, Schizophrenia, depressive illness and alcohol abuse. Hoarding tendency and extent can be formally assessed using questionnaires like Saving inventory-revised and Clutter image rating in some cases along with frontal lobe battery for executive functioning. 

Interventions

Treatment of the underlying pathology is of foremost importance. Effective CBT-centered approach along with the use of Selective Serotonin reuptake inhibitors and antipsychotics is considered to be beneficial, along with treatment of the underlying associated condition such as Dementia. Where possible, an outpatients approach is considered useful rather than an inpatient setting. If needed, patients with a severe disorder might need a higher care facility. Unfortunately, patients are seen to revert back to their original lifestyle after some time. In most cases, they refuse to seek help from the services despite rigorous interventions from animal welfare organizations and health services. Some individuals have even moved homes in a desperate attempt to avoid identification. Ethical issues might arise in situations where patients have capacity and are non-

Key Points

1. Diogenes syndrome in the context of animal hoarding; Noah's syndrome is a condition characterized by extreme hoarding behavior including hoarding of living animals as well as inanimate objects. The living conditions tend to be poor and the subject has an inability to recognize the condition as a hindrance to day-to-day life.

2. This condition is commonly seen in elderly patients usually with an underlying psychiatric condition such as dementia and untreated depression.

3. They require an expertly performed assessment. There is a need for multidisciplinary team intervention including social services and animal services. However, many patients may relapse after disengagement with the services.

MCQs

1. In Individuals with Diogenes syndrome, the best evidenced based psychological treatment intervention is:
   A) Interpersonal therapy
   B) CBT
   C) Behavioral Therapy
   D) Cognitive Analytical Therapy
   E) Eye movement desensitisation and reprocessing.

2. One of the most treatment resistant compulsions in OCD is:
   A) Symmetry compulsion
   B) Hoarding compulsions
   C) Handwashing
   D) Checking and hoarding
   E) Checking only

References

Patient opinion to the Use of Depot and Oral Antipsychotics at Caludon Centre: A Survey

Dr Alex Denning (FY2) & Dr Rupinder Kaler (Consultant)

Background

Depot medication is a very practical and robust treatment option which may be being underutilised in NHS. In conditions such as schizophrenia, depot medication is shown to reduce relapse rates and improve adherence when compared to oral medication; this is beneficial for the patients wellbeing and also reduces the burden on the National Health Service. Even though there are now several second generation antipsychotics in the form of a depot, with better tolerability and side effects, old stigmas surrounding depot injections still run and run deep. Depot antipsychotic medication is often seen as a “last resort” or for patients who are deemed unlikely to comply and it is less common to see them prescribed in first presentations of psychosis.

Evidence suggests early and effective treatment dictate patients prognosis and life span and has added economic advantages to the NHS which the treatment is Government led and funded. Patients may be open to the idea of a depot injection for treatment and we aimed to study their attitudes towards depot injections. With evidence showing improvement in adherence, lower rates of relapse and hospitalisation, improved quality of life and satisfaction and that patients on depot prefer being on them then why are they not started sooner in appropriate patients?

Aims

The objective of this survey was to study patient attitudes towards both oral and depot medication. Depot medications were not always indicated in all patients treatment which we thought helped give us a general flavour of opinions of a variety of mental health patients. We aimed to seek patient preference and to establish reasons for their choices.

Method

A survey was created as demonstrated in the figures opposite.

The cross-sectional survey was conducted over one week at the 5 acute inpatient wards at the Caludon Centre, an acute mental health hospital in Coventry, UK. Each patient was seen face to face, provided information about the survey and given a choice to answer the questionnaire anonymously. All patients were admitted for a variety of diagnoses.

Out of a total of 84 patients, 52 participants responded; making the response rate of 59%.

<table>
<thead>
<tr>
<th>Total respondents</th>
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<tbody>
<tr>
<td>Females 25</td>
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<tr>
<td>Males 27</td>
</tr>
</tbody>
</table>

Aims

- Are you on antipsychotic medication? Yes/No
- Has depot medication been discussed with you? Yes/No
- Have you been offered depot medication? Yes/No
- Are you currently receiving depot medication? Yes/No
- Have you received depot medication? Yes/No
- Is this your first admission or have you had previous admissions?........

Would you prefer depot or oral medication? Depot/Oral

Why would you prefer depot injections?
- Do not have to worry about tablets
- Less chance of relapse
- More contact with CPN or community team
- More confidence in depot over oral medications
- More control over illness
- Other

Why would you prefer oral medication?
- Depot injections are invasive/painful
- Needle phobia
- More control over medication
- Stigma surrounding depots
- Time consuming going to get depot injection
- Other

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Results

Numbers: Of the 84 inpatients, 17 patients were deemed unsuitable to ask due to disturbed mental state or were off the ward for leave at the time of data collection. 15 patients refused to answer the questions or were unable to understand the questions being asked. 52 patients were able to answer the questionnaire fully.

Demographics: There was a good split between males and females (27:25 respectively). The youngest patient was 17 and the oldest 73, with an average age of 43.

For 12 patients it was their 1st admission, the 40 other patients had >1 admission under mental health services.

16 patients were informal, 7 were under section 2 of the Mental Health Act and 26 under section 3 of the Mental Health Act.

Preferences: The patients were given the choice of deciding if they would prefer depot vs oral medication: 29 chose oral medication and 23 chose depot medication. They were able to chose one or more of the reasons displayed in the charts below.

Conclusion

There was a relatively even split of preferences for either oral or depot medication, with males preferring depots and females oral medication. The main factor for depot preference was it removed the need to remember daily tablets, whereas for orals the leading reason was that depots are seen as invasive and painful. Less number of patients refused depot on the grounds of stigma.

An important factor learnt from this survey is that all patients (with a variety of mental health illnesses) show a similar preference to oral medication than depot. Secondly depots are not being discussed with more than half of the patients and hence not offered soon enough. Reasons for patient choices have been highlighted enabling physician understanding for reasons for patients potential medication choices early on.

Useful follow up to this survey would be to survey prescribing clinicians, evaluate their perception of use of depots and orals amongst patients and compare both the results.
Introduction
BSMHFT provides mental health care to those people living in Birmingham and Solihull who are experiencing mental health problems. National reports recently have focused on patients breaching A&E targets, waiting for inpatient psychiatric beds and the pressures on GP & acute services. There has not been much attention paid to the impact of the delayed discharges in acute mental health units. BSMHFT in liaison with local authority also manage step down crisis /respite homes to minimise delayed discharges. Delayed discharge means that the Service User is clinically ready for discharge from Psychiatric hospital but the team are unable to facilitate discharge due to lack of social care support and accommodation etc. which act as barriers to discharge. The Department of Health published its good practice guidance on delayed discharges in 2003(3) which was followed by the Community Care (Delayed Act 2003)

Aim of this study was to estimate the proportion of delayed discharges with the reasons and make comparisons with national benchmarks.

Methods
The study was conducted in an acute inpatient male psychiatric unit with 16 beds. We looked at electronic records for patients admitted to an acute psychiatric unit in West Birmingham inner city area from October 2016 to January 2017. In addition to identifying patients whose discharges were delayed with the associated reasons, the data collected included basic demographics, referral source, mental health act status, care clusters, presenting issues, capacity assessments, physical health assessments, risk assessments and relevant physical health investigations.

Results
We found in our evaluation 33 % of discharges were delayed. There was up to 1 week delay in 16%, up to 2 weeks delay in 6% and more than a month delay in 10 % of inpatients. Capacity assessments and risk assessments were documented in 100 %, allergy status was documented in 97%. Physical health assessments were completed in 93 %, Blood tests were done in 93 % and ECG in 75 % of patients

Discussion
Delayed discharge is a major problem in mental health. The Department of Health guidance on delayed transfer of care(3) placed new duties on local authorities and the NHS to work together and provide community care for patients discharged from acute hospitals, prevent unnecessary admissions and promote patient independence.

The true cost of delayed discharges in monetary terms to the NHS is not exactly known. As per NHS reference costs guidance (2), a mental health care cluster (per bed day) is around £324. This involves direct costs – which can be easily identified with a particular activity (e.g. consultants and nurses) and Indirect costs – which cannot be directly attributed to an activity but can usually be shared among a number of activities (e.g. laundry and lighting). In addition there are also overheads cost, which relate to the overall running of the organisation (e.g. finance and human resources).

Conclusion
Delayed discharges were identified as significant problems (33%) in comparison to the Rcpsych Commission’s report in 2015 (16 %) 1

Delayed discharges can clearly have an impact on patient’s recovery, sometimes even contributing to relapse with repeated or prolonged admissions thus leading to being institutionalised and finding it harder to resume normal life. They can also contribute to significant financial & resource implications on the trust & NHS.

References

Service evaluation: Impact on delayed discharges in an acute inpatient Male psychiatric unit.
Dr Neelam Kataria ST6, Dr Vinod Singh Consultant.
BSMHFT Mary Seacole House, Lodge Road, Winson Green, Birmingham B18 5SD
Using a Hand model in promoting resilience in Syrian Refugees in Germany

Dr Sarah Abd El Sayed, and Dr Karim Rajput

Introduction and Background

Many refugees suffer from mental health disorders as a result of experiences living in or escaping from their turbulent homelands or as they settle in their new host countries. As such, it is important to intervene during the early stages of refugee resettlement to help prevent or mitigate mental illness symptoms. However, because of several access and utilization barriers, such as stigma, refugees are not apt to receive needed mental health services. Moreover, the traditional Western model of treatment can be culturally incongruent with refugee practices. Research has highlighted the importance of recognizing the resilience and agency of refugees and the need to better understand the different methods of coping with traumatic events and new and challenging circumstances of displacement. Moreover, resources must be understood in terms of the individual’s needs, personal goals and the demands he or she encounters. Each of these concepts must be examined in the context of the pre-migration, flight and post-migration phases. [1-3]

At a social gathering 40 newly arrived families of Syrian Refugees in Germany, a package entitled ‘Arab Resilience” was delivered and data collected, including PHQ-9, GAD-7, scores and psychosocial interventions.

Method

The ‘Psycho-Social Hand’ model uses fingers in the drawing represent people who such refugees would seek support from. The palm represent two activities they would engage in to cope with stress and finally the wrist represent two phrases that they would say to themselves to deal with such stress. 17 individuals completed Hands. These were then translated from Arabic into English and then analyzed.

Results

All the individuals included in the sample reported that they would ask for support from their families, friends or someone known to them. Three said they would ask God and two reported that they would consider their own selves as their route of support. Interestingly, only one person wrote that they would seek help from a medical professional.

Regarding looking at an activity to help coping with stress, ten individuals said that sport in general is helpful. Five individuals said that they would prefer just to "go out" and another five said that they would prefer to listen to music. Two individuals reported that they would pray. Individual responses came for activities like (taking a shower, sleeping, drinking tea, cooking, drawing and seeking medical advice and taking medications). One of the individuals did not write any activity that they would engage in to cope with stress.

Six respondents said that they would advise themselves that the future will be better. Also, four individuals said that they will challenge/overcome stress. Another four used some self-consolation phrases in such circumstances. Three people said to themselves that “they are fine” and two people preferred using some religious phrases. Two individuals did not write any phrase at all.

Conclusion

It is evident from the above model done among these Syrian refugees that they would mostly ask for support from people known to them rather than thinking to seek help in any other formal way. It is likely that stigma may prevent individuals from seeking help from psychiatrist or mental health professional.

Easily accessible activities like sport, listening to music and spending sometime outdoors were the most common activities they would think of to deal with stressful situations. Positive self talk like hoping for a better future, trying to overcome the stressful situation and self-consolation was the main inner dialogue that would be helpful.

References

**Monitoring of Mental Health Act Code of Practise 2015 Compliance in Cases of Section 136 Detention Brought to Place of Safety/AE Department**

Dr Nusrath Ali Baig (Staff Grade), Dr Mahmood Nasiri (Staff Grade), Dr Mohammed Shaffiullha (ST6), Dr Dinesh Maganty (Consultant)

**Introduction**

The Mental Health Act 1983 allows the police to remove a person appearing mentally disturbed who is ‘in immediate need of care control’ in a public place to place of safety. The Emergency department (ED) has been accepted as a place of safety along with designated health-based places of safety (POS) to carry out a mental health assessment. Patients brought under S-136 are subject to detention in ED or POS. This study was carried out to explore the adherence of best practice as defined by the Mental health Act and Code of Practice.

This Monitoring review was conducted as part of the clinical governance process for assurance.

The CQC in their latest review of places of safety notes that

Too many providers are not appropriately monitoring their own service provision. Many places of safety could not give us basic information about the use of their service or how often people were turned away, or excluded, and the reasons for this. In addition, not all providers said they collected all the monitoring data required by the MHA Code of Practice. This makes it difficult for those providers and their commissioners to evaluate if provision is meeting the needs of people in their local area.

The CQC review also notes that

We found that the target times for starting assessments varied considerably between places of safety. Over half were already setting target times of two hours or less to begin assessment and, overall, almost three-quarters set target times within three hour standard. Less than 10% of places of safety did not have a specified target time, or their target was only to complete the assessment within the statutory 72 hours. Nearly two-thirds of places of safety had set target times for completing the assessment. Of those, the majority aimed to complete their assessments within six hours.

The most common reason nationally for delays was because the AMHPs were not available. We raised this issue in the MHA Monitoring report for 2012/13. Although the MHA Code of Practice does not set a required number of AMHPs, it does state that local authorities must provide an around the clock service that can respond to patients’ needs

**The Mental Health Code of practice states:-**

16.47 Assessment by the doctor and AMHP should begin as soon as possible after the arrival of the individual at the place of safety. In cases where there are no clinical grounds to delay assessment, it is good practice for the doctor and AMHP to attend within three hours; this is in accordance with best practice recommendations made by the Royal College of Psychiatrists. Where possible, the assessment should be undertaken jointly by the doctor and the AMHP.

16.51 If the doctor sees the person first and concludes that they have a mental disorder and that compulsory admission to hospital is not necessary, but that they may still need treatment or care (whether in or out of hospital), the person should still be seen by an AMHP. The AMHP should consult the doctor about any arrangements that might need to be made for the person’s treatment or care.

**Aim of the Review**

The purpose of the review was to establish the implementation of the Mental Health Code of practice which states that when a patient is brought in detained under section 136:-

1) There should be a Joint assessment by the doctor and the AMHP where ever possible.

2) This should occur within 3 hours.

3) Where a Joint assessment is not possible (this should be exceptional) the AMHP should see the patient any way even if not detained under the Mental Health Act.
Methodology

A retrospective review was conducted involving 44 patients brought under section 136 of MHA in the month of October 2016 to either the Place of Safety or Emergency Department. The data was collected via RIO records and paper-based records maintained by the admin department. Information was obtained about the time of presentation to POS/ED, time scale of assessment under the MHA, if joint assessment was performed, whether the patients were discharged or transferred to mental health services and the final outcome following the assessments.

Results

Fig 1- Total no. of patients undergoing formal MHA assessments

There were 44 patients brought to Place of safety (POS)/Emergency Department (ED) under section 136 of the MHA in the month of October 2016. Of the 44 patients, 32 (73%) patients had a formal joint assessment, 30 patients had a formal mental health act assessment and 2 patients had a joint assessment by one doctor and AMHP. 10 patients (23%) were seen by only doctors without AMHP and 2 (4%) of the patients were not seen either by doctor (section 12) or an AMHP. 32 patients were assessed in place of safety and 12 patients in ED (City hospital (10), University hospitals of Birmingham (1) and Solihull hospital (1).

Fig 2- Time period of Mental Health Act/ Joint Assessment of patients in POS/ED

Out of 32 patients, 21 (66%) of patients were seen within 3 hours of referral to MHA team, 9 (28%) patients were seen above 3 hours and there was no information about the timings of assessment for 2 (6%) of the patients. All the 10 patients seen by only doctors were seen within 3 hours. 2 patients were not seen by either the doctor or AMHP.

Fig 3- Outcome of patients formally assessed under Mental health Act assessment

In total 30 patients were formally assessed under MHA assessment. 11 (37%) patients were detained under section 2 of MHA, 8 (27%) patients were admitted informally, 5 (16%) under Home Treatment Team support and 6 (20%) patients discharged with no further follow up.

Fig 4- Outcome following discharge from S 136

22 patients (50%) were admitted to hospital out of which 11 patients were detained under Section 2 of the MHA, 14 (32%) were discharged and 8 (18%) were referred to Home Treatment Team (HTT).
Recommendation

1. Increase compliance with the mental health act code of practise from 73% to 100%.
   - Set a target time of 3 hours for commencement of mental health act assessment to achieve this in line with national practise.
2. Current high rate of compliance with the code of practise is in line with National practise.
3. A 50% admission rate and 80% of patients requiring ongoing Secondary mental health services follow up post Section 136 suggests that a there is a high rate of Mental health morbidity and need in this patient group and suggests that the police officers are identifying need appropriately.

Key Outcomes

- 32 (73 %) of patients were assessed according to the Section 136 policy.
- 12 (27 %) of patients were not seen by AMHP as part of a joint assessment or subsequently and no reasons were provided in the records for non assessment of the patients.
- 2 patients were not seen by both doctors and AMHPs. 1 patient was seen by only a nurse who sought advice from consultant and 1 patient seen by non S 12 doctor. Both the patients were discharged without follow up.
- 10 (23%) of the patients had a single assessment by Section 12 approved doctor.
- Majority of the patients 30 (68%) were either admitted or referred to community team for further follow up and 14 (32%) were discharged with no further follow up.
- 24 (80%) were referred to mental health services for support following MHA assessment and 6 (20%) of them were discharged without further follow up.
- Out of 32 patients, 21 (66%) of patients were seen within 3 hours of referral to MHA team and 9 (28%) patients were seen above 3 hours.
- Advise was sought from Mental Health practitioner in 40 patients but there was no information if advise was sought for 4 patients.

Discussion

The study highlighted that the Section 136 policy was being implemented in vast majority of cases though not being fully implemented in a minority of cases by the Mental Health Team. Though not all patients brought to the AE or Place of safety under Section 136 were jointly assessed by the doctor and AMHP. a majority of the patients had a formal joint assessment and assessed within the 3 hour time limit set out by the Royal College of Psychiatrists.

References

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Q2) A, B, D, E

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Q1) B
Q2) D

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