Health Education Thames Valley

MENTAL HEALTH ACT

MODULE: MENTAL HEALTH ACT ASSESSMENT IN COMMUNITY

TARGET: PSYCHIATRY TRAINEES ST4-6 INVOLVED IN MHA ASSESSMENTS

BACKGROUND:

Senior trainees are often expected to undertake assessments under the Mental Health Act as part of their out-of-hours contract. This work is usually undertaken without senior supervision and without adequate preparation. While all Section 12(2) doctors are required to attend a course, typically lasting two days, covering this work, before they can apply to become approved under the Act, these courses are of variable content and quality. As autonomous practitioners however, there is little expectation that trainees will seek advice or senior input relating to this work, which meant there is little opportunity to observe examples of good practice or share challenging experience with other trainees.

This scenario is designed to highlight some of the issues which can arise in the course of undertaking Mental Health Act assessments in the community and offer trainees the chance to consider and explore these outside the challenging environment of the assessment itself.

RELEVANT AREAS OF THE CURRICULUM

Curriculum	Details
ILO – 1 Assessment	Demonstrate the ability to undertake a thorough assessment including where possible obtaining all relevant information Assess and manage patients with multiple and complex pathologies Identify urgent psychopathology
ILO – 2 Formulation	Demonstrate the ability to construct formulations that include differential diagnosis, liaising with other agencies and specialists and making appropriate referrals
ILO – 3 Management and Treatment	Demonstrate the ability to use information obtained to inform an appropriate management plan taking into account biological, social and psychological domains
ILO 4 Risk	Demonstrate expertise in applying the principles of crisis intervention in emergency situations Make care plans in urgent situations where information may be incomplete
ILO 9 Work effectively with colleagues	Show competence in supervised autonomous working Use effective negotiation skills Manage divergent opinions on patient treatment or intervention
ILO 17 Act in a professional manner at all times	Maintain good professional attitudes and behaviour when responding to situations of ambiguity and uncertainty Support and advise colleagues in dealing with complex professional interactions Recognise own limitations

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INFORMATION FOR FACULTY

LEARNING OBJECTIVES

- Greater confidence in undertaking Mental Health Act assessments
- An understanding of standards of practice expected
- An understanding of the concepts and issues underlying these situations
- An opportunity to share concerns and explore issues with other trainees

SCENE SETTING

Location:	Training room/Simulation suite		
Expected duration of scenario:	20 mins	Expected duration of debriefing:	40 mins

EQUIPMENT AND CONSUMABLES

Mobile phone
Chair

PERSONNEL-IN-SCENARIO

Patient
Girlfriend
Doctor

PARTICIPANT BRIEFING

Faculty Introduction:
We are going to watch a scenario based on a real life situation which resulted in a complaint from the police. Details have been changed to protect confidentiality. The scenario has been modified for educational purposes. You will see a few short scenes showing how the scenario evolved. We will stop the scenario at various points for your thoughts and discussion.

FACULTY BRIEFING

This scenario involves a number of short interlinked vignettes. The facilitator's role is to stop these at appropriate points and generate a discussion around what the trainees have observed. There are some prompts in the script to offer guidance to facilitators although there are many other points which could be discussed depending on the group.

'VOICE OF THE MANIKIN' BRIEFING

No manikin

IN-SCENARIO PERSONNEL BRIEFING

See below

ADDITIONAL INFORMATION

Scene 1

The duty psychiatrist is just leaving work. He has been called to do a Mental Health Act assessment. He phones the crisis team for information.

(on the phone, bored)
Hi, is that the Crisis team? Hello it's Dr Carrick, I'm the on-call reg. I've just finished work and I'm off to see Mr…. (looks at scrap of paper) Haki at his house. Yes, he's the man the GP and the police called about this morning. They've been pestering me all day to go and see him but I've been busy doing my ARCP stuff. I think the police officer left me three messages!

I just called the AMHP who said they were miles away so I'll just get on and see him as we probably won't admit him anyway. So I don't know anything about this man - apparently he has been under you before is that right? So what do you know about him? ….
He's a nightmare is he? …So he's just a crackhead? And a drinker? And he seeks medication? ….(listens)

So he uses drugs then goes a bit crazy, then gets violent and threatens the girlfriend? Has he been in hospital before? A few times. So your advice is…(laughs) "do not admit him under any circumstances". And what's the bed situation? No beds anywhere in the Trust. Ok then, well I'll call you when I've seen him. Should be pretty quick.

STOP

Initial thoughts?
What are psychiatrists assumptions?
Does he have enough information?
Will he go in with an open mind?
Do you make decisions based on bed availability?
What about speaking to the police who know him?
Is it reasonable to leave an assessment like this until later in the day?
Do you consider the patient and relatives experience enough?
Do you trust your colleagues including the police and GP to make a reasonable assessment?

Scene 2:

The psychiatrist arrives at the house and knocks on the door. A young woman (the girlfriend) opens the door. The doctor is not wearing a badge.

Dr: Hello, I'm the duty reg. I would have been here earlier but I had to park miles away. Bit dodgy round here isn't it? I'm here to see Mr Haki. Is he in there? (points into living room)

She says yes and he goes straight in.

STOP

How could he have approached this differently?

Consider personal safety. In fact there was a samurai sword on the wall in the room, near the patient. Be aware that patients own homes are full of potential weapons.

The doctor goes in to see Mr Haki by himself, leaving the girlfriend in the kitchen. Mr Haki is pacing and looking agitated. Sits himself in a sofa with the patient between him and the door, bag on lap. Does not appear to look around the room at all. Crosses legs away from patient. Body language closed.

Scene 3:

Dr: Hello Mr Haki, I'm Dr Carrick. Please have a seat? The police have asked me to come and see you for a psychiatric assessment. So, what's been going on then?

Mr H: Are you the Crisis Team?

Dr: I'm the duty psychiatrist.

Mr H: (agitated, pulls hair, talks fast) "I'm losing the plot man. I can't go on like this. (shouting, distressed) I just don't know what to do any more! I' don't want to hurt anyone. I need help but you lot never help me. You never fucking help me!"

Dr: Now please don't get upset with me. We haven't even met before. I'm just here to do my job. Can you tell me what's brought all this on? I hear you've been drinking today, is that right?

Mr H: Don't you fucking judge me. You don't know anything about me. I've been asking and asking for help but you lot haven't done a thing to help me. What am I supposed to do huh? (stops for a minute ?distracted by voices) You don't know what it's like to live with this inside of you. You can't escape what's inside can you? Tick tock. When it's your time it's your time.

Dr: I'm not sure I understand what you mean. Just calm down, have a seat and tell me what's bothering you.

Mr H: They're all bothering me. Them lot next door who won't leave me alone, always calling me a grass and I never even done nothing to them. (distracted, laughs inappropriately then punches his hand) I don't want to hurt anyone.

Dr: How much have you had to drink today?

Mr H: (distracted)

Dr: Mr Haki?

Mr H: Yeah, of course, it's the only way to stop them.

Dr: Right, well obviously it's difficult to do a proper assessment on you if you are under the influence of drugs and alcohol. Is there anywhere you can go until things calm down here?

Mr H: I don't want to hurt her but they tell me to (clenches fists, starts crying)

Dr: I'm sure you are not going to do anything like that. It probably hasn't helped that you have been drinking so much lately. Alcohol does make you more depressed you know. What do you think we can do to help things?

Mr H: I don't want to but I think I need to go to hospital, away from her, away from here.

Dr: Well there are no beds at the moment. And I'm afraid you don't meet the criteria for the Crisis team because of your drinking.

Mr H: So what am I supposed to do?

Dr: Well I'm sure things will look better in the morning when the alcohol is out of your system. Is there somewhere you can spend the night?

Mr H: No, there's nowhere. This is the only place that's safe. They can't see me here. (Pauses for a moment then says) No, he's not.

Dr: He's not what? … Well I don't think you need to come to hospital at the moment. It would probably be best to go somewhere else tonight – I'll arrange it with the police officer. If you think you need some help ask your GP to refer you back to your local mental health team. Are you on any medication?"

Mr H: I've run out

Dr: Well you need to get yourself to your GP for another prescription tomorrow. OK, Good (gets up to go) Nice to meet you.

STOP

Was he polite? Compassionate? Did he explain who he was and why he was there?
Did he put the patient at ease?
How did the patient feel? (Not taken seriously, not listened to, not hopeful)
What is the girlfriend thinking?

What issues are they considering here? (Child protection, adult safeguarding, risk to partner, risk to others.?)
Does the psychiatrist have enough information? DON'T be afraid to revisit your original diagnosis and make a different plan. There was still time to salvage this.

Scene 4:

Standing by the door in view of patient.

Dr: Hi Ann, it's James. I've just seen Mr Haki. Yep, just to confirm he doesn't need to come in. He's had a bit too much to drink but he's much calmer now and I'm sure he'll be fine in the morning. We've made a plan for him to go somewhere else tonight and he will collect his prescription in the morning. Can you let the AMHP know she doesn't need to come. Yep, I'll write it all up on Rio tomorrow.

Scene 5:

Speaks to girlfriend. Does not ask their names or get any information from them.

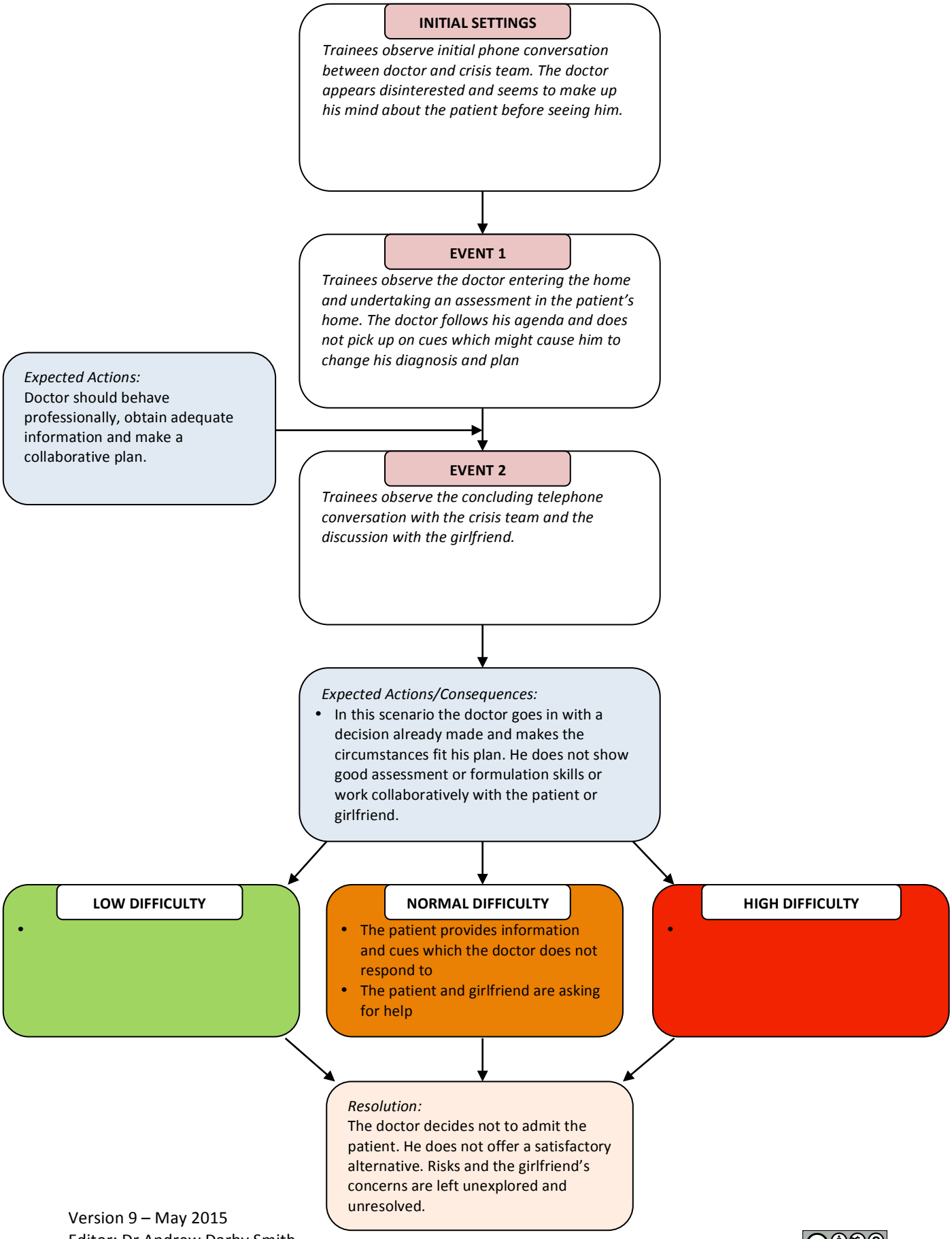
So I've spoken to Mr Haki and he doesn't need to come in to hospital.
He says he has run out of medication so I've told him he needs to collect more tomorrow. You should contact your GP tomorrow and have a chat with them about what to do. I'll ask the police officer outside to take him somewhere tonight until he sobers up. OK?

STOP

How he could have approached this differently?
Consider collaborative management with relative, record keeping, communicating essential information.

END

CONDUCT OF SCENARIO



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Original Author: Dr L Tate

DEBRIEFING

POINTS FOR FURTHER DISCUSSION

Faculty - What Actually Happened

The scenario happened much as you saw except there was a police officer in the house with the girlfriend as well. The officer knew the man and the family well having been there many times and was sympathetic to their situation. They both felt the man had not up to now received the help he needed.

The police were called to the address by the girlfriend who said Mr Haki was unwell again and felt she and the child were in danger from him (yes, there was a child in the house). He confessed to the police officer that he locks himself in the shed when the voices are bad as he is afraid he will hurt someone. He self medicates with alcohol to manage the distressing voices. He told them he doesn't want to live like this and often thinks about hanging himself or jumping onto a train track. He doesn't want to leave his girlfriend and child though. He threw a table through the TV recently in response to voices and frustration. He takes himself off into the forest camping for days when unwell as he is so afraid he will act on the commands he hears including to kill his girlfriend and their child.

The psychiatrist checked whether a bed was available before he saw the patient and obviously based their decision on this fact. The Crisis team did say the patient was a 'nightmare' and suggested it was all self induced due to substance misuse. The doctor ignored the police officer who knew the man really well and was familiar with his symptoms, tragic story and risks. He also ignored the girlfriend who was really concerned for her safety and that of her child and had useful information relevant to diagnosis and risks. She remained very supportive of Mr Haki and was really concerned for his health and safety.

The doctor failed to communicate a proper diagnosis or risk assessment and made a decision about admission based on assumptions and incorrect information. After the doctor left the man was removed from the house by the police officer who could not allow him to remain and was taken to a railway station with a blanket as somewhere quiet and better than the homeless hostel. The officer knew that the man would not do well in such a noisy chaotic environment.

The man phoned the police officer a couple of weeks later from a local psychiatric hospital to thank him for talking to him like a human and trying to get him the help he needed. He said he had eventually been sectioned and was relieved that he had been diagnosed with schizophrenia and was being established on antipsychotic medication which was already having a significant impact on his voices and distressing experiences. He had been self medicating with medication and stopped this once he was stabilised on prescribed medication. His risks were considered sufficient to warrant a forensic assessment. After several weeks in hospital he eventually returned home with a keyworker and regular follow up. He continues to have a relationship.

Consider your own thinking in decision-making [1]:

> **Familiarity bias** – we all have an in-built tendency to believe information from people we know. So if a friend or colleague gives you information you are more likely to believe what they tell you, even if it is not the whole truth.
>
> **Confirmation bias** - We are likely to confirm what we already think is going on. So if you think someone's primary problem is alcohol dependence you are likely to ask questions to confirm this and not pursue other possible options. Simply being aware of this makes it more likely you will consider other options.

[1] See Thinking Fast and Slow by Daniel Kahneman where some of these ideas are explored in more detail

What you see is all there is – we can't think of things we can't think of! So if you don't actually make yourself consider other possibilities you will make decisions based only on the information you have in front of you, assuming this is all the information there is.

Take your time. The best decisions are made by people with enough information and enough time to think about them, regardless of their expertise. Taking the time to gather as much information as possible from multiple sources and think about it carefully is essential. Clearly there is a balance to be stuck but ask yourself if you have enough information to make a sensible and justifiable decision. Could there be other factors you are not aware of?

PSYCHIATRY SCENARIO 8 - HANDOUT

INFORMATION FOR PARTICIPANTS

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KEY POINTS

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WORKPLACE-BASED ASSESSMENTS

Curriculum	**Details**
ILO 1,2,3,4,9,17	CBD, CP, Mini-PAT, supervisors report

FURTHER RESOURCES

Mental Health Act Code of Practice

PARTICIPANT REFLECTION

What have you learned from this experience? (Please try and list 3 things)

How will your practice now change?

What other actions will you now take to meet any identified learning needs?

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PARTICIPANT FEEDBACK

Date of training session:.....

Profession and grade:.....

What role(s) did you play in the scenario? (Please tick)

Primary/Initial Participant	
Secondary Participant (e.g. 'Call for Help' responder)	
Other health care professional (e.g. nurse/ODP)	
Other role (please specify):	
Observer	

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
I found this scenario useful					
I understand more about the scenario subject					
I have more confidence to deal with this scenario					
The material covered was relevant to me					

Please write down one thing you have learned today, and that you will use in your clinical practice.

How could this scenario be improved for future participants? This is especially important if you have ticked anything in the disagree/strongly disagree box.

FACULTY DEBRIEF – TO BE COMPLETED BY FACULTY TEAM

What went particularly well during this scenario?

What did not go well, or as well as planned?

Why didn't it go well?

How could the scenario be improved for future participants?