INTRODUCTION

Mental disorder is very common at all ages. It affects one person in four at some point during their life. It varies from anxiety and phobic states and mild depression through to serious disorders including severe depression bipolar affective disorders and schizophrenia. Some of the severe disorders may be recurrent, relapsing and remitting, and enduring. Other disorders may be provoked or maintained by or associated with consumption of alcohol and other substances. The presentation may be a first contact with a patient who has a new disorder or a person with an exacerbation of a chronic problem that the mental health services already know about.

Most patients have insight into their problems. Others may have impaired insight or lack it. Some of them may voluntarily agree to accept help whether or not they have insight and / or capacity. However, others may need to be compelled to receive an assessment and treatment, possibly against their will, usually using powers given by the Mental Health Act 1983 (England and Wales). In addition, there may be a physical disease or substance-related (including conditions related to licitly prescribed, and non-prescribed, licit or illicit substances) cause for altered mental states that, usually, resolve with treatment of the underlying problem.

DEFINITIONS

Often, colloquially, all problems and disorders that affect people's mental health are referred to as *'mental health problems'*. Such broad use of this term gives little indication of the severity of the condition or of the likely course of events in particular patient's circumstances. Sometimes, people who have a severe mental disorder are described as having a mental illness. This guideline uses the term *'mental disorder'* to distinguish those conditions that are primarily related to people's mental ill health from the very common and understandable anxieties and emotional reactions of people who are casualties or who require an ambulance service for any other reason.

ASSESSMENT

Approach

Many patients are upset, distressed, anxious, suspicious, disorientated or agitated when faced by Ambulance Clinicians. While considering their own safety, the approach taken by ambulance crews to patients whose behaviour appears concerning should be calm and gradual, relying on the persuasive powers of the clinicians to achieve a conversation and then assessment. Non-verbal indicators such as the patient's appearance or level of agitation should be noted as part of the risk assessment.

The environment may give important clues, such as the presence of medication or a backdrop of chaotic living conditions.

Do not rush. A distressed person may react very badly to rush and hurry. Take time to explain your actions to both the patient and the relatives and always endeavour to be honest about what you are going to do and what is likely to happen.

History

As with any presentation, a history outlining the nature of the complaint is required. This should be carefully explored, with particular reference to previous mental health service involvement, prescription medication, the level of alcohol use and potential substance misuse. Details of the nature of the problem, the presence of hallucinations or delusions, whether visual or auditory, and the patient's thoughts about their experiences and problems are key.

Examination

Physical illness can present as an apparent mental health problem and clinical examination and testing is needed to exclude causes such as hypoglycaemia, head injury, meningitis/encephalitis and intoxication. As part of the assessment of mental state, note should be taken of the following:

ABNORMAL APPEARANCE/BEHAVIOUR:

- anxiety
- agitation
- mood
- orientation in time, place and person
- lack of attention/concentration/distraction
- poor memory
- unusual form/content of speech
- expressed thoughts
- beliefs/hallucinations being described.

If possible, a physical examination with primary observations should be undertaken and recorded. The other features are established from the nature of the consultation and by observation.

CAPACITY

Each Ambulance Service should have a formal process or protocol for establishing the capacity of patients to consent to assessment and to being transported for further care. When patients are willing to accept the assistance offered, there is little difficulty. If they have capacity and decide that they do not wish to accept the treatment offered, then, usually, this must be respected. It is good practice to inform the patient's General Practitioner and the identified Social Worker, if there is one, about this decision. The process should be thoroughly documented using the Ambulance Trust process.

Application for powers to compulsorily assess and treat mentally disordered patients in the face of their refusal

Readers should be aware that, in the current mental health law in England and Wales, application for patients' detention, and compulsory assessment and treatment, against their will if necessary, does not turn directly on tests of capacity, but on certain features of the nature and degree of their mental state and any mental disorder thought to be present at initial assessment, and certain circumstances relating to their needs and risks to themselves and others. Most patients who are detained using the Mental Health Act 1983 do have impaired capacity for their mental disorder, at least, but it is possible that some may not. Also, some incapacitous patients may not satisfy the conditions for compulsory detention, assessment or treatment. Therefore, assessment of patients in these circumstances is a specialised matter. Ambulance clinicians should seek the advice of a Doctor and / or an Approved Social Worker (ASW) if they think that a patient is in this situation.

In the event of refusal and provided that certain conditions are satisfied, then legislation allows for compulsory admission of patients to an appropriate facility for assessment under a Section of the Mental Health Act 1983 for England and Wales (Scotland implemented new Mental Capacity legislation and a new Mental Health Act in 2005).

Due note should be taken of capacity or its impairment in particular cases as a component of assessments of mental state and the potential requirement for application for compulsory powers. Applications are most often made by an ASW after their own assessment and require recommendations from at least one, but, usually, two medical practitioners. In the vast majority of circumstances, at least one of the medical practitioners has, or is required to have, special experience in assessing and managing mental disorders that is substantiated by their recognition under section 12(2) of the Mental Health Act 1983 (England and Wales).

Plainly, conducting this process can take time. Reasonable and proportionate steps can be taken to prevent patients from immediately harming themselves or posing a risk to others while awaiting this assessment, but if physical restraint is required, the Police should be involved. Authority to move patients against their will must come from the ASW who acquires the power to convey patients and to request the support of ambulance staff and / or the police once he or she has made a formal application using the Act. Moving some patients may require the assistance of the Police.

MANAGEMENT

Risk Assessment

A full risk assessment usually involves a thorough assessment. Not all aspects can be carried out by Ambulance Clinicians in emergency circumstances. One of the most concerning aspects of risk assessment relates to a patient's potential for self-harm and, possibly, suicide. This guideline includes a brief method for assessing these risks in ***Appendix 1***.

Violence

Ambulance crews should make an assessment of their personal risk when approaching upset, distressed, disorientated, agitated or threatening patients. If the risk is considered significant, the Police should be called to assist. Safe restraint can only be provided safely with sufficient trained people. It needs more than two people!

Specific Mental Disorders

MOOD, STRESS-RELATED AND ANXIETY DISORDERS

These are the most common groups of problems and often represent the extremes of normal emotion. Depression, panic disorder, phobias and obsessional conditions fall into this category. There may be considerable distress, but the patient usually has insight into their problem.

PSYCHOSIS

This is a general term that describes a group of disorders in which the patient tends to be severely distressed and may not appear to be rational. They may interpret events in a manner that does not appear

to be appropriately in touch with reality. They may have strongly-held beliefs that are unusual or unsubstantiated by events. In this situation, they may be described as having delusions. Patients may perceive voices that are not heard by others (called auditory hallucinations). Thus, delusions and hallucinations and impaired insight may appear to assessors to be core symptoms.

MANIA / HYPOMANIA

These patients are often overactive and may have not slept properly for days. They tend to be obsessional and persistent in their behaviour. They have rapid thought processes and tend to tire out their relatives and friends. Patients with mania often suffer from delusions, often delusions of grandeur.

SCHIZOPHRENIA

This is a common and often severe mental illness. It may present acutely with severe change in behaviour or insidiously as a slow but progressive change over a period of time. A patient may be deluded. This means that he or she may strongly hold beliefs that appear inappropriate to the assessor in the context of the patient's life, culture, and circumstances. Auditory hallucinations (false perceptions in which the patient can hear voices, not heard by others, that are talking to them or to another about them) may be a feature, and can cause great distress. Their behaviour may be reported by other people as seriously disordered or irrational, or the patient may show patterns of behaviour and speech that suggest that they might have hallucinations and / or delusions, or they may report such occurrences.

Ambulance clinicians should be aware that these features can also occur in the presence of physical disease, intoxication with licitly or illicitly obtained substances, and under the influence of psychotropic drugs.

PARANOIA

Paranoia can be a feature of both depression and schizophrenia and is normally associated with the patient suffering delusions of persecution. They can be extremely suspicious and can react unpredictably, aggressively or violently. Care should be taken to provide reassurance and avoid provocation.

Table 2 – Drugs used in mental health

Hypnotics /Anxiolytics	Benzodiazepines are among the most frequently used drugs in this category. They can be used to help induce sleep and also to reduce anxiety. In excess they are principally sedative.
Antidepressants	This category includes a number of different groups of drugs that are used over months rather than days, and some types may take up to three weeks to begin to show an effect. Some of the older drugs, the tricyclic antidepressants, are very dangerous in excess. Agitation followed by sedation and cardiac dysrhythmias are the most significant effects in poisoning. The newer antidepressants, such as the serotonin re-uptake inhibitors (SSRIs) are used much more often now. They too can cause significant side-effects too. Monoamine oxidase inhibitors (MAOIs) are now little used, except in cases that have been resistant to more recently developed drugs. The group has an important range of severe drug interactions and, in the ambulance context, morphine and nalbuphine must be avoided. As an interaction, they can cause a dangerous increase in blood pressure.
Antipsychotics	Also known as neuroleptics, these drugs can be taken orally or given by injection and are powerful tranquillizers. They can be used in acute situations to sedate, but are most frequently used in the medium to long-term management of disorders such as schizophrenia.

COMPULSORY ASSESSMENT, TREATMENT AND DETENTION USING THE MENTAL HEALTH ACT 1983

The principal series of orders from the Mental Health Act 1983[1] (England and Wales) that are applicable to the pre-hospital environment are described here. The legislation allows for patients' compulsory admission to hospital. Its use requires a formal application to be made, usually by an ASW (who is specially trained and authorised to do this work), but, occasionally, the patient's nearest relative (the nearest relative is also defined by law for this purpose), but applications also require medical recommendation(s). There are extensive safeguards to prevent abuse of these powers, but, in essence, ambulance crews may be lawfully empowered by the ASW to convey a patient against the patient's wishes. If there are concerns about the safety of the patient or the clinicians, the Police should be requested to assist.

Section 2 – Admission for Assessment

This allows for admission for a period of up to 28 days primarily for the purposes of assessing a person suffering from a mental disorder of a nature or degree that warrants detention and where it is in their own interests or the interests of public safety.

Section 3 – Admission for Treatment

With similar criteria for application as Section 2, this order allows for admission for up to six months and is used to compel treatment of the patient. The ASW requires the consent of the nearest relative.

Section 4 – Admission for Assessment in an Emergency

Admission for a period of 72 hours can be compelled on the application of an ASW or the nearest relative with the recommendation of one Doctor who has prior knowledge of the patient (often the patient's General Practitioner). The applicant should have seen the patient in the previous 24 hours.

Section 135 – Place of Safety Order (private)

Section 135 allows magistrates to make an order that empowers the Police to enter a private dwelling for the purpose of removing a person thought to be suffering from a mental illness to a Place of Safety. The ASW who applied for the order must be present during the execution of the warrant.

Section 136 – Place of Safety Order (public)

Section 136 empowers the Police to remove a person who appears to be suffering from a mental disorder from a public place to a Place of Safety for the purposes of assessment by an ASW and a Doctor. A Place of Safety may be the local Police Station or a hospital but this should be defined and agreed locally and in advance. Local arrangements will apply in respect of where the Doctors who assess the patients subject to Section 136 come from.

Key Points – Mental disorder

In a situation in which there is a distressed patient who appears to be suffering from a mental illness:

- Ambulance clinicians should consider their personal safety before approaching the patient
- A history and examination should also include an assessment of the mental state of the patient
- Capacity to consent must be assessed
- In certain circumstances in which risk of harm to the patient or to others is thought to relate to a disordered mental state, the patient should be protected from causing further harm to themselves or others; an ASW and a Doctor should be asked to assess the patient and consider application for a Section under the Mental Health Act 1983.

REFERENCE

[1] Bluglass R, Beedie MA. Mental Health Act 1983. *British medical journal* (*Clinical research ed*) 1983;287(6388):359-60.

METHODOLOGY

Refer to methodology section.

Appendix 1 – Suicide and Self-harm Risk Assessment Form

Item	Value	Patient Score
Sex: female	0	
Sex: male	1	
Age: less than 19 years old	1	
Age: greater than 45 years old	1	
Depression / Hopelessness	1	
Previous attempts at self harm	1	
Evidence of excess alcohol / illicit drug use	1	
Rational thinking absent	1	
Separated / Divorced / Widowed	1	
Organised or Serious attempt	1	
No close / reliable family, job or active religious affiliation	1	
Determined to repeat or ambivalent	1	
Total patient score		

< 3 = **Low Risk**
3-6 = **Medium Risk**
> 6 = **High Risk**