Holding powers in A&E departments

A cause for concern

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The Mental Health Act as an instrument of statute law is unable to address practicalities of caring for mentally disturbed persons who are awaiting formal detention. The common law relevant to this area is ill-defined and depends on interpretation of precedent. The resulting confusion and consequent problems will become more apparent with the advancement of community care, and is a matter which warrants urgent review.

Legal provisions for care of the mentally ill presenting to accident and emergency (A&E) departments are contradictory and deficient. The Mental Health Act (MHA) (1983) for England and Wales, is necessarily limited in its scope regarding the practicalities of emergencies; and doctors and others confronted by immediate dilemmas may have reservations about acting with 'common sense' under common law, seemingly with good cause. A recent case is described to illustrate the difficulties sometimes encountered, followed by a discussion of pertinent points.

Case report

A psychiatric registrar was contacted by the A&E department for telephone advice regarding a man in his 20s presenting to them for help with 'a drink problem', and decided to go and see the patient himself. The A&E department is approximately one mile distant, and in practice necessitates a car journey from the psychiatric unit. It was quickly apparent that the patient was floridly psychotic. Assessment was difficult because of thought disorder, but persecutory delusions were evident, and he was intermittently preoccupied in a manner consistent with experiencing auditory hallucinations, delusions of thought control or passivity experiences. Enquiry into the nature of his difficulties was met by alternating expressions of profound perplexity or fear. He volunteered being affected by 'poisonous fumes' and alluded to suicidal ideas. It was established that he had no fixed abode and no close relatives.

The need for admission was explained to the patient who seemed ambivalent to the suggestion, but did not refuse or protest. Arrangements were made with the duty doctor at an acute unit some 10 miles away, following the zonal system in operation. The duty consultant psychiatrist was also briefed and warned that compulsory admission might be necessary. It was decided by the consultant to admit informally if possible, and an ambulance was summoned to see whether this was feasible before invoking the MHA.

For the whole of this time (approximately 30 minutes), the patient remained scared and suspicious. He intermittently made to leave the interview room 'to escape', but was easily distracted and persuaded to stay.

The registrar was then bleeped by his own unit as there had been a violent incident and his attendance was requested urgently. Assistance was sought from A&E nursing colleagues to observe the patient and dissuade him from leaving if necessary. This was declined, as they were of the opinion that they were neither obliged nor resourced to stay with psychiatric patients. The registrar asked to speak to the consultant in charge of the department, who explained that his medico-legal information was that he could not prevent the patient from leaving in any way, and had no sanction to do so under common law. These discussions took 5–10 minutes during which time the patient disappeared from the department. Police were subsequently informed but were unable to trace the man's whereabouts. There was no further contact with hospital services so far as is known.

Comment

Laissez-faire attitudes and champions of civil liberties on the one hand, are countered by equally compelling exponents of the ethics of common responsibility and 'duty of care' on the other. The obligation on an individual to act in emergencies is accepted even in the litigious climate of the USA. In situations where the

patient is incapable of giving valid consent, and harm from failure to treat is potentially imminent, care must be provided. Third party interests must also be considered when other patients, co-workers or potential victims of harm or violence are forseeably recognised (Rice & Moore, 1991). The American Psychiatric Association's indications for restraint include "to prevent harm to the patient or other persons when other means of control are not effective or appropriate" (Lavoie, 1992).

In the UK, the MHA legislates regarding mental health, and common law applies only in those areas where the MHA is 'silent'. The case above illustrates the difficulty in deciding when it is appropriate and/or legal to detain a person during the period taken to invoke care under the MHA. Statute law is difficult to apply in certain situations such as this, and this is recognised in the Code of Practice (para. 9.3) in relation to operation of section 5(4) (Department of Health and Welsh Office, 1993). Here, however, it is accepted that detention may be necessary even before 'proper assessment' where 'potentially serious consequences' are feared if the patient is successful in leaving in an acute emergency. In similar circumstances not covered by the MHA, it is clear that recourse to 'common law' cited by many doctors when confronted by these tricky situations is fraught with difficulty, even when the individual concerned is known to be mentally disturbed and a possible risk to himself or others. 'Common sense' responses in these complex situations become increasingly blurred, especially when professionals take differing views, which may be coloured by disparate priorities or personal beliefs.

English law is refined by 'test cases' interpreting legislation in more obscure circumstances. In *Black* v. *Forsey*, 1987, S.L.T. 681, *The Times*, May 31, 1988, the House of Lords held that *hospital authorities* have no authority under common law for the detention of patients, on the grounds that the Act provides comprehensive provision in this area. This referred to the continued detention of a patient in Scotland because renewal arrangements had not been completed, rather than emergency admission. However, Lord Keith accepted that *private individuals* have a common law power to detain "in a situation of necessity, a person of unsound mind who is a danger to himself or others". But according to Lord Griffiths this power "is confined to imposing temporary restraint on a lunatic who has run amok . . . a state of affairs as obvious to a layman as to a doctor" (Jones, 1994). This appears to preclude its use in patients such as the one described above, where although the person has been identified as mentally disordered and at risk, he is nevertheless passive and non-violent.

Other authorities take differing views. Professor Brenda Hoggett, a law commissioner, suggests that common law powers "can probably be summed up by the proposition that there is a right to restrain a patient who is doing, or is about to do, physical harm to himself, to another person, or to property" (Hoggett, 1990). This may extend under the common law doctrine of necessity (according to Lord Goff) to the administration of a short-acting sedative if (a) the patient's mental disorder precludes any rational communication with him, and (b) a reasonable person would conclude that such action would be in the patient's best interests (Jones, 1994). Finally, although the European Convention on Human Rights reiterates that a person of unsound mind can only be held "in accordance with a procedure prescribed by law", the European Court of Human Rights has ruled that this excludes emergency confinement (Jones, 1994). In the case described, it is debatable whether Hoggett's criterion of "about to do" could be fulfilled, yet perhaps more likely that Lord Goff's second principle given in relation to administration of sedatives would be accepted. Furthermore, the Mental Health Act Code of Practice (which is not legally binding) at paragraph 15.24 seems to envisage that in rare cases it is appropriate under common law to administer medical treatment for mental disorder to a highly disturbed patient (but one who is capable of giving or withholding consent) if their behaviour is an immediate danger to themselves or other people. The administration of such treatment would often necessitate the use of restraint in practice.

The circumstances in which it is wise to adopt a proactive approach to keep patients safe are thus problematical and a source of much anxiety in those trying to provide care. It is curious that the MHA allows a police officer to detain someone who is found in a 'public place' (which would include A&E departments), and who, 'appears' mentally disturbed, for up to 72 hours under section 136; yet there is no provision for detention over shorter periods of non in-patients who have been assessed, confirmed as mentally disordered, and for whom compulsory care is being arranged. In the case described, it is possible with the benefit of hindsight to criticise delay in invoking a medical recommendation for formal detention caused by efforts to admit informally, although such a stance could itself be criticised by some as in contravention of the 'spirit' of the MHA. Moreover, the same difficulty, namely that of 'restraint' would still pertain over the inevitable finite period while necessary application for detention was made. This raises the related question as to whether common law could more easily be cited as grounds for necessary supervision during the period where

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a formal medical recommendation for detention under the MHA has been made, but obtaining of necessary second opinions and related documentation awaited.

On balance it seems pragmatic to argue that an individual who is known to be mentally disordered should be supervised while the MHA is being invoked. Indeed, the possibility of doctors being criticised and subjected to medico-legal sanction in the event of such an individual coming to harm or harming others is intuitively greater than the risk of being successfully sued for battery if acting in good faith in such instances. The Code of Practice (para. 18.7) recommends that "Where it is likely that, in a group of patients, problem behaviour may appear unpredictably, an agreed strategy for dealing with the unanticipated events should be developed". Importantly, Hoggett reinforces this, advising that response to such incidents should be worked out in advance by those likely to be involved. It follows that A&E departments and psychiatric services should develop joint policies for the care of such patients, including a strategy to manage people at risk who wish to abscond.

Recent innovations such as the Care Programme Approach are aimed substantially at ensuring 'seamless' care provision, and sit uneasily against the ad hoc response to the acute situation described. Such presentations will increase as a result of hospital closures and instigation of community care (Weissberg, 1991). Revision of the MHA to address this uncertainty would be difficult, but clarification in the Code of Practice of relevant common law precedents and circumstances in which they can justify actions by professional carers is warranted.

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