Festival psychiatry

ARTICLE

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SUMMARY

This article is based on our experience of volunteering for the charity Festival Medical Services, to provide mental healthcare at the Glastonbury Festival of Contemporary Performing Arts and the Reading Festival. It describes the history of these annual events and the development of medical and psychiatric services offered. Principles of assessment and management of mental disorder in festival settings are outlined and common psychiatric presentations are described. Legal aspects of care are discussed. The article is intended primarily to inform others of this interesting and unusual form of mental healthcare and we hope that aspects of our experience will prompt reflection on psychiatric practice in other settings.

LEARNING OBJECTIVES

- Understand how psychiatric care is provided at the Glastonbury and Reading Festivals
- Recognise the symptoms and signs of organic and functional conditions likely to present to psychiatrists at festivals
- Identify the principles of psychiatric management in festival settings

DECLARATION OF INTEREST

I.R. and R.B. gain free entry to the Glastonbury and Reading Festivals through their voluntary work with Festival Medical Services.

Background

After two small gatherings in the early 1970s, the Glastonbury Festival of Contemporary Performing Arts began as an annual event in 1979. It has become the largest green-field festival in the world, taking place on 900 acres of rural farmland in Somerset, a southern English county. It is staged over 5 days at the end of June and attracts around 175 000 campers, comprising 135 000 ticket-holders and 40 000 support staff. As well as live popular music from various genres, the festival showcases a plethora of dance, comedy, theatre, circus and cabaret acts. The festival site is located 8 miles from the town of Glastonbury and 19 miles by road from the nearest general and psychiatric hospitals, both in Yeovil.

The Reading Festival is the world's oldest ongoing popular music festival. It is held on a thin strip of farmland enclosed on three sides by the eponymous Berkshire town in the south of England. It is staged over 4 days on a national public holiday weekend at the end of August, attracting around 90 000 people, most of whom camp on site. It began with jazz music in the early 1960s, evolving into a rock festival by the mid-1970s. Today, the festival focuses on live guitar-based rock music, although other musical genres and comedians also feature. The Reading site is just 2 miles from the nearest general and psychiatric hospitals.

Festival Medical Services

The organisation Festival Medical Services (FMS) began in 1979, when a small group of local doctors provided medical care at the Glastonbury Festival. This provision has continued annually, allowing FMS to develop into a provider of comprehensive medical services and, since 1993, it has also covered the Reading Festival. It provides medical care at a dozen or so other public events in the south of England that are not of a nature that requires specialist psychiatric services. FMS is a not-for-profit limited company with charitable status and is registered with the Care Quality Commission (CQC), the regulator of healthcare providers in England. Its main purpose is the relief of sickness by the provision of medical services and emergency healthcare at public gatherings. Surplus income is donated to various charitable causes, mostly in low- and middle-income countries.

FMS recruits volunteers from a range of healthcare professions, including doctors, nurses, advanced nurse practitioners, paramedics, pharmacists and radiographers, as well as trained first responders, porters, administrators, receptionists and others. Typically, volunteers are afforded free entry to the event at which they provide input, with designated camping areas in which the amenities are generally superior to those on the main festival site.

Medical facilities

The medical facilities at Reading are provided in a large marquee, set up as a field hospital, close to the main arena. There is a reception and waiting area, with a retail and dispensing pharmacy. The adjoining clinical area contains cubicles, created by canvas partitions, that are used for patient assessment and treatment. There are resuscitation facilities, with a consultant anaesthetist always available. Basic

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radiology is provided in a mobile unit parked adjacent to the tent. There is no chemical pathology facility. Additionally, a medical team, or 'pit crew', is on duty at each of the two largest stages during performances. There is an on-site ambulance service. Psychiatric facilities are described below.

The same facilities are provided at Glastonbury, but on a larger scale. Given the vast extent of the festival site, in addition to the main medical facility towards its north-east perimeter, there are three further minor-injury units and a second pharmacy elsewhere on the site. There are several pit crews, working at the larger stages, roving first responders and paramedics, and a fleet of on-site ambulances.

Psychiatric provision

Previous literature

There has been one previous description of mental health services at Glastonbury in the psychiatric literature, which describes a single shift by a psychiatrist (Knight 1995). There have been newspaper reports describing mental healthcare at Glastonbury and other festivals (Sampson 1995; Hillier 2016). Our literature search did not find other accounts of festival psychiatry.

History

Mental health services were first provided at the Glastonbury Festival in the late 1980s, by a small group of psychiatrists and registered mental health nurses on an on-call basis. Most assessments were carried out at the main premises of festival welfare services and many patients were seen where they presented, at various points around the festival site. Interventions consisted of advice, brief support and occasional treatment with oral tranquillising drugs. From the mid-1990s onwards, there was an expansion in mental health staffing and the current model of care, in which mental healthcare is provided by a team based at the main festival medical centre, was established at Glastonbury and Reading.

Psychiatrists of all grades were recruited in the early years of mental healthcare provision, whereas those volunteering now must be approved under section 12(2) of the Mental Health Act 1983 (MHA) for England and Wales and maintain expertise in the management of psychiatric emergencies in the course of their main employment. Experience of festival psychiatry is desirable and a cohort has formed of psychiatrists who have worked for FMS for many years, with new volunteers introduced as vacancies arise.

Facilities and staffing

At each festival, a separate area of the medical centre is devoted to the assessment, observation and treatment of patients presenting with psychiatric symptoms and signs. At Reading, psychiatric facilities are situated in one corner of the main unit, with floor space for a small seating area and between four and six inflatable mattresses, on which patients are able to rest and sleep. The area can be divided into two or three sections by canvas partitions. At Glastonbury, an equivalent area is formed by a small marquee attached to the main medical facility, with space for seats and up to eight mattresses.

The psychiatric area is staffed at any one time by two or three mental health practitioners, who are either registered mental health nurses or mental health social workers. Some of these may be approved mental health professionals (AMHPs) under the MHA in their main employment, but this function is not provided by FMS. Any MHA assessments carried out on the festival site are coordinated and led by an AMHP from the duty team provided by the local authority.

The mental health practitioners are supported by a psychiatrist who remains present at the mental health facility during the period of peak demand, between early evening and the early hours of the morning, and is available on an on-call basis at other times. At Glastonbury, six psychiatrists work a rota to provide cover for the 6 days on which there is public access to the festival site. At Reading, four psychiatrists provide cover over 4 days.

Access

Many patients self-present to the main festival medical centre or are brought there by family or friends. Some present to welfare services, which have well-established links with FMS and a high proportion of staff with experience of mental healthcare through their main employment. This allows timely identification of people for whom onward psychiatric referral is needed. Festival stewards help people who appear to be in need of psychiatric assessment to find their way to the festival medical centre. FMS paramedics are available to carry out initial assessments at the place of presentation and, if necessary, will transport the patient to the medical centre by ambulance. There is a police presence on the festival sites and officers will assist with conveyance, if needed to maintain safety. Members of the FMS mental health team will see patients away from the main medical centre, but this is seldom required.

Patients presenting to the main medical facility are initially triaged by a general nurse, with physical observations completed routinely, and those assessed as requiring psychiatric intervention are brought to the mental health area. This step in the assessment pathway is bypassed if immediate psychiatric attention is needed. Assessment and treatment of patients with general medical and psychiatric needs takes

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place in liaison with FMS colleagues working in the main medical area, either sequentially or jointly, with communication facilitated by the co-location of services, shared clinical records and governance arrangements, joint handovers between shifts and working relationships that have developed over many years.

Assessment

One of the mental health practitioners makes an initial assessment of patients transferred to the mental health area and, in many instances, will be able to provide any advice and intervention required without involving a doctor. The main triggers for involving a psychiatrist are listed in Box 1. Additionally, at busy times, the psychiatrist helps meet demand by carrying out a share of initial assessments. Team members assess patients as they would in any psychiatric provision, according to their professional training, while their experience of festivals and festival psychiatry helps in their understanding and formulation of patients' presenting problems and needs.

Treatment

Attendance at the mental health area can be therapeutic in itself. The facility is shielded by canvas from rain and sunlight and can be heated when necessary. Levels of sensory stimulation are much lower than elsewhere on the festival site. Comfortable seating is available and there are mattresses and blankets that afford the opportunity for rest and sleep. There is a plentiful supply of beverages and toast. Team members, including the psychiatrists, strive to be engaging and empathic.

Some patients require only advice or signposting to other on-site services. There is close liaison with the welfare team, facilitated by co-location of the medical and welfare tents at Reading and close proximity of these two services at Glastonbury. Advice about psychotropic medication is provided by the psychiatrist, typically to people undergoing treatment elsewhere who have developed adverse effects following a recent change in their drug regime. Occasionally, patients present having forgotten to bring medication to the festival or having lost it on site. There is a pharmacy based in the festival medical centre that can dispense medication prescribed by FMS doctors. Although the pharmacy stock of drugs is relatively limited, medication can be ordered and supplied from off the festival site within 24 h.

Most patients who remain in the mental health area for treatment have conditions likely to improve spontaneously, for which observation and supportive treatment, aimed at reducing distress and maintaining safety, are usually sufficient. Such care is most often required by patients presenting with anxiety, paranoia and disorientation. Intervention primarily involves talking to them, with the aims of establishing trust, promoting orientation in place and person, providing distraction from symptoms, giving advice on self-management and helping patients understand their experiences. Oral diazepam is offered to a minority of patients for its anxiolytic and hypnotic effects. Other drugs are seldom prescribed.

An important part of patient management is the resolution of the practical concerns that can be a cause or consequence of the presenting mental disorder. These include lost property, problems with camping, disruption of arrangements for travel home and, for those employed on site, work commitments. Strategies such as problem-solving, involvement of family and friends, and joint working with welfare services, campsite stewards and work supervisors are all used with good effect.

Friends and family members are able to remain with patients in the mental health area and their support and familiarity with the person can be invaluable. Often though, companions choose not to stay, having already spent time trying to cope with the presenting problem. They may need a break or choose not to miss more of the festival entertainment. Some are unsettled by having seen someone close to them become unwell and may require brief support and explanation of what has happened.

BOX 1 Reasons for involving psychiatrist following mental health triage

- Neuropsychiatric or physical symptoms
- Diagnostic uncertainty
- Concern about risk
- Medication advice or prescription
- Impaired mental capacity
- Mental Health Act assessment required

Liaison with other services

Some patients present with a pre-existing mental disorder. They may experience a relapse of symptoms during the festival or find that symptoms that were present beforehand are harder to manage in the festival environment. Some will have come to the festival in the hope that attendance will improve a deteriorating mental state. Liaison with the patient's local mental health service is attempted in all such circumstances. Management focuses on identifying strategies that have been useful

previously and mental health staff using their professional expertise and knowledge of the festival environment to suggest other ways to achieve mental well-being. Repeat attendance at the mental health facility for support and review during the festival can be helpful. FMS welcomes prior contact from mental health services and carers about people with a history of mental disorder who may require psychiatric care during the festival.

Some patients choose not to remain at the festival following deterioration in their mental health or have symptoms that require treatment beyond the duration of the festival. A care plan for management of symptoms during their journey home and for the next few days is agreed with them, involving family and friends if possible, and follow-up in primary care or by their local mental health service is arranged. Occasionally, typically once or twice during each festival, patients are too unwell to be managed safely by the festival mental health team and are either admitted to an acute psychiatric in-patient unit or transferred to an emergency department in a general hospital for investigation of organic causes of their presentation. This is facilitated by prior liaison with the National Health Service (NHS) trusts in whose catchment areas the festivals take place, to establish lines of communication and protocols for safe transfer of care. There is also advanced planning with the local social services duty team, in case it is necessary to carry out a MHA assessment on the festival site. This joint working has been facilitated at the Glastonbury Festival in recent years by the presence on site of mental health managers from Somerset Partnership NHS Trust.

Demographic factors

Individuals requiring mental healthcare at the Reading Festival are typically younger than those at Glastonbury and alcohol use is more commonly a feature of their presentation. Reading Festival takes place in late August, during the UK school summer holiday. Its location provides easy access by public transport. The musical acts on offer appeal predominantly to young people. Accompanied children are allowed, but their attendance is discouraged, and there are no child-oriented activities. Glastonbury takes place in school term time and the festival has specific provision for families with young children. The entertainment appeals to a wider age range than at Reading, with more established performers and heritage acts likely to appeal to older people. The remote location of the Glastonbury Festival means that alcohol can only be purchased at relatively high prices on site. The Reading Festival site is a short walk from supermarkets.

The number of psychiatric presentations at the Glastonbury Festival peaked in the late 1990s and has since reduced. The festival rose in popularity during the 1990s and attendances swelled, as television coverage began and a national daily newspaper became a sponsor. The festival site has a large perimeter and it was historically possible to gain access without a ticket and avoid detection once inside: it was estimated that 250 000 people were present in 2000, despite only 100 000 tickets having been sold. This prompted improved ticketing and security arrangements, including a 3.5 m metal perimeter fence, from 2002 onwards. Tickets for the festival became a much-sought commodity, selling out quickly and becoming most accessible to organised and determined people who have good internet access and are able to afford an entry price of over £200. A cheaper alternative is to work at the festival in return for a ticket, for example as a steward or litter-picker. Paid work is also available with the many site vendors and security team, which recruits staff from throughout the UK. Psychiatric presentations have diminished at Glastonbury since 2002 and now include a greater proportion of people employed at the festival. Reduced attendances and demographic differences between the paying and working populations seem likely reasons for these changes.

Environmental factors

The programme of live acts at festivals starts around noon, with headliners appearing towards the end of the day. Morning is a time of sleep for many, and mental health presentations between sunrise and early evening are few and typically less acute. In the past, substance-related presentations would often coincide with live performances by popular electronic dance music acts, but this association has been less pronounced since the introduction of 24-hour dance areas. A small number of people present with panic symptoms after being caught up in the crowd surges that occur during certain genres of musical performance. Mental disorders causing recurrent self-harm are encountered more frequently at Reading, where the musical acts are more likely to present themes of nihilism and despair. The nature of such presentations does not support a direct causal link and more probable reasons for the association are the younger age demographic at Reading and the musical culture of the festival.

Environmental factors have an influence on risk assessment. Festivals are busy places at which it is hard to go unnoticed, with high levels of staffing and a strong commitment to the welfare and safety of those attending. As a result, risks of suicide and self-neglect in individuals with persisting conditions

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are usually likely to increase following departure. Self-neglect is a greater concern when the site is wet and muddy or in hot sunshine. Camp fires pose a particular hazard.

Common clinical presentations

Alcohol and substance-related disorders

As is the case in any other place in the UK where adults gather to enjoy the company of others and listen and dance to contemporary music, alcohol and other substances are used at the Reading and Glastonbury festivals. Alcoholic drinks can be purchased from official vendors at both events. Use of illicit substances is discouraged at both festivals, with searches by security teams on entry and a police presence on site. Despite the large numbers of people in attendance, there is very little public disorder.

A common presentation to the medical facilities is ataxia combined with an impaired level of consciousness caused by substance intoxication. Alcohol intoxication alone is not usually offered as a reason for such presentations by patients and their companions. Some admit to consuming other substances, whereas others postulate that their drinks have been 'spiked' without their knowledge. Presumably these claims are sometimes made to avoid admission of illicit substance use or indicate the patient's misjudgement of the amount of alcohol consumed and their physiological tolerance to it. These presentations with acute physical effects of alcohol and substance intoxication are primarily managed by the FMS general medical team, with monitoring of physical observations, including blood glucose, and nursing in the recovery position to reduce the risk of aspiration. The mental health team provides this care when it has greater capacity to do so than the general medical facility.

Substance dependence or withdrawal is seldom a reason for presentation. Acute alcohol withdrawal cannot be safely managed on site and would prompt onward referral to the local general hospital, unless the patient opted to manage symptoms by drinking alcohol and it was relatively safe for them to do so. Opioid substitution therapy is not prescribed on site.

Substance-induced psychosis is a common presentation, with typical symptoms including psychomotor agitation, suspiciousness, perplexity, anxiety, depersonalisation, derealisation, mood changes, thought disorder and paranoid delusions. Auditory and visual hallucinations occur but are less common. In some cases there are features of delirium, with fluctuating levels of attention and disorientation in time and place.

BOX 2 Symptoms and signs of serotonin syndrome and other hyperthermia syndromes

Serotonin syndrome

Mental status:

- agitation or restlessness
- confusion
- coma

Autonomic overarousal:

- raised pulse and blood pressure
- dilated pupils
- tremor
- diarrhoea
- hyperpyrexia

Neuromuscular abnormalities:

- shivering, or muscle twitching
- muscle rigidity, or loss of coordination
- hyperreflexia

Other hyperthermia syndromes

These have a similar presentation and include:

- anticholinergic toxicity (some illicit drugs are laced with anticholinergics)
- neuroleptic malignant syndrome (caused by antidopaminergic drugs)
- malignant hyperthermia (caused by general anaesthetic drugs)
- lethal catatonia
- exertional heat stroke

(Ahuja 2009)

Involuntary movements, including dystonia, dyskinesia and chorea, are a recognised feature of acute intoxication with some illicit drugs and are usually benign in nature (Deik 2012). It is important in such cases to exclude more dangerous causes of neuromuscular abnormalities, in particular serotonin syndrome, other hyperthermia syndromes and hyponatraemia. These potentially fatal conditions can be associated with substance misuse, particularly of stimulant drugs. Their symptoms and signs are summarised in Boxes 2 and 3.

Most cases of substance-induced psychosis resolve within 2–8 h of presentation to the FMS mental health team. Management is centred on reduction of distress and maintenance of safety until spontaneous improvement occurs, as described earlier. The drugs most commonly implicated are cocaine, amphetamine, 3,4-methylenedioxymethamphetamine (MDMA or

BOX 3 Symptoms and signs of hyponatraemia

- Nausea and vomiting
- Fatigue
- Headache
- Restlessness
- Irritability
- Muscle weakness, spasms or cramps
- Hyporeflexia
- Confusion
- Seizures
- Coma

(Biswas 2007)

BOX 4 Options to be considered in the absence of mental capacity to consent to treatment

- Continuing treatment in the festival medical centre, if this is in the patient's best interests and the interventions required do not amount to a deprivation of liberty
- Transfer to a local hospital, using the authority conferred by the Mental Capacity Act (an option most likely to be considered when physical investigation is needed to exclude an acute organic cause)
- Discussion with the police regarding conveyance to a place of safety under section 136 of the Mental Health Act
- Contacting an approved mental health professional to request a formal assessment under the Mental Health Act

'ecstasy'), ketamine, lysergic acid diethylamide (LSD or 'acid') and novel psychoactive substances. Cannabis alone, even in its high-potency forms, is seldom implicated, unless it has been consumed orally, baked in biscuits and cakes: enteral consumption results in delayed onset of action and greater potential to use more than was intended. FMS recently treated a man with anxiety and paranoid delusions that appeared to be induced by caffeine-rich 'energy' drinks and sleep deprivation.

BOX 5 Case vignette: Mark

Mark, a 32-year-old man, is brought to the festival medical facility by a friend. At initial triage assessment, he presents as frightened and confused, with limited awareness of his surroundings. Physical observations are normal. He is compliant with the requests of his friend and medical staff and is willing to be taken to the psychiatric facility. He is unable to give much history himself, tending to give very brief answers to questions. His friend says Mark regularly engages in recreational use of drugs and has been taking cocaine and 'acid' during the past 8 h. He drank one can of cider 4 h ago. There is no known history of mental disorder.

On examination, Mark is hypervigilant with a staring gaze; he acts in a guarded and suspicious manner but is cooperative. He is fidgety but able to sit down. His speech is almost monosyllabic. He is anxious and scared, with a perplexed affect. Ideation is difficult to elicit; he is disoriented and unable even to state where he is.

His friend remains with him and the mental health nurses on duty regularly spend time with him, reassuring him and reminding him where he is and who they are. Despite this, he remains highly distressed, and attempts at orientation and reassurance are seemingly unsuccessful. The psychiatrist talks to him and offers 5 mg of oral diazepam. Mark does not have the mental capacity to make a decision about this, but seems willing to take it. A best interests decision is made, involving his friend, to administer the drug.

Mark remains distressed for a further 30 min, after which he gradually becomes less frightened. Around 1 h after administration of the medication, he lies down on a mattress and sleeps for the next 4 h, during which time he is nursed in the recovery position and his respiratory rate is recorded every 30 min. When he wakes, he is tired but lucid and oriented. He is grateful for the care he has received and apologetic for any trouble he has caused. Prompted by one of the mental health nurses, he reflects on the risks associated with substance use. He leaves for his campsite in the company of his friend.

Functional psychotic disorders

Acute transient psychotic disorder is a differential diagnosis of the brief psychotic presentations seen by festival psychiatric services. Theoretically, the powerful psychological experience of festival attendance could precipitate such episodes, but a history of recent substance use is nearly always revealed eventually.

Some patients presenting with psychotic symptoms do not improve during their contact with the festival mental health team and require onward referral, either for hospital admission or, in less severe cases, to their local community mental health services. Anecdotally, the factors that predict such an outcome are not surprising. Patients who have not used illicit substances, have experienced a longer duration of symptoms and have a history of psychosis are more likely to have symptoms that persist. Awareness of these risk factors allows provisional plans for ongoing care to be made at an early stage.

Depressive and anxiety disorders

The most common reasons for people with depressive episodes and generalised anxiety disorder (GAD) seeking help from festival mental health services are unrealised hopes of an improvement in mental state at the festival and difficulty being around people intent on enjoying themselves. Such presentations are infrequent and the opportunity to talk and reflect with a mental health practitioner is usually all that is needed. Severe cases of depressive illness or GAD are not encountered, presumably because onset is usually gradual and people experiencing such episodes are unlikely to attend festivals.

People with agoraphobia and social phobia who present are typically first-time attenders who have underestimated the effect the festival will have on their condition. Rehearsal of anxiety management techniques and planning a festival itinerary that avoids the most feared situations, ideally with involvement of companions at the festival, are the interventions most frequently used. Some patients are overwhelmed and decide to leave the festival. Very occasionally, a person has experienced a panic attack on initial arrival at the festival gate and been brought by ambulance to the festival medical centre, from where they have made arrangements to be conveyed home without ever setting foot on the main festival site.

Acute panic triggered by the sensation or fear of being crushed in a crowd is a common presentation. Typical cases are women of below-average height,

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who have been lifted off their feet during a crowd surge while watching a musical performance and have experienced the sensation of being unable to breathe for a short period owing to chest compression. Management consists of exclusion of chest injury, followed by standard interventions for a panic attack.

Personality disorders

Presentations to festival mental health services include people with emotionally unstable, anxious or dependent personality features that have become problematic as a result of interpersonal problems or challenging circumstances. Such presentations are typically of people in their mid to late teens at the Reading Festival and seldom involve those old enough for a diagnosis of personality disorder to be made. Supportive listening, problem-solving and help with practical issues are usually all that is required.

Legal aspects of care

Festival sites are considered public places for the purposes of section 136 of the MHA. The police very occasionally use this legal power at Glastonbury and Reading to detain people who appear to be mentally disordered and in immediate need of care. The remote location of the Glastonbury Festival meant that people detained under this power in the past needed to be conveyed many miles to the nearest designated place of safety. This process was invariably a negative experience for the people detained and had resource implications for the police and local NHS providers.

Since 2015, a temporary place of safety has been established on the Glastonbury site, in a small portable cabin adjacent to the psychiatric area of the festival healthcare facility. This allows for assessment of people detained under section 136 by the psychiatrist on duty, supported by mental health practitioners. This creates the potential for the situation to be resolved within the festival site, such that section 136 can be revoked, if clinically appropriate, in consultation with an AMHP. Alternatively, a formal MHA assessment can be carried out on the festival site or the police can be advised to convey the patient to another place of safety provided locally by the NHS. Use of the on-site place of safety is audited and reviewed following each festival, in line with the MHA Code of Practice (Department of Health 2015).

There are also temporary facilities on the festival sites in which the police hold people in custody following arrest. The FMS psychiatrist is occasionally asked to assess a person so detained who appears to the police to have a mental disorder. This is conducted according to standard practice for assessments in police custody (Kent 2010).

There are occasions at each festival when it is necessary to apply the Mental Capacity Act 2005 (MCA). As described above, the festival mental health team often manage patients with acute mental disorders that are likely to resolve spontaneously. These patients may, at times, not have the mental capacity to make decisions about their treatment. They may be vulnerable to exploitation, at risk of physical harm, or pose a danger to themselves or others. As a result, physical interventions or administration of tranquillising medication may be required. Detention under the MHA would be a disproportionate response if, as is often the case, the condition could be safely managed by the festival mental health team and the patient

BOX 6 Case vignette: Kieron

Kieron, an 18-year-old man, has self-presented, alone, to the medical centre at the Reading Festival, concerned by thoughts he is having about jumping in front of a train at the nearby railway station. He came to the festival with a group of people, only one of whom he knows well. He has always found meeting unfamiliar people to be difficult and has become increasingly self-conscious during the festival, worried that his anxiety around his new companions has caused him to appear foolish. He has been despondent and lethargic for the past 6 months and attended his local hospital emergency department 5 weeks ago after cutting his forearm, leaving before psychiatric assessment could take place. His general practitioner (GP) had prescribed citalopram, which Kieron stopped after 4 weeks because he felt no better. He had hoped that attendance at the festival would lift his mood and improve his confidence. He has recently completed an information technology course at college and is looking for work. He lives with his mother and does not want to burden her with his problems.

The on-call psychiatrist is contacted because of the potential risk of suicide. By the time she arrives, one of the mental health practitioners on duty has established a good rapport with Kieron and the psychiatrist joins their conversation, going over the psychiatric history and carrying out a mental state examination. She finds Kieron to be shy, anxious and despondent. Speech is normal and his mood lifts when talking about a musical act he enjoyed on the first day of the festival. He is disappointed by his festival experience and is pessimistic about his future; it is when talking about these matters that thoughts of suicide enter his mind. There are no other abnormalities of mental state and nothing to suggest alcohol or substance intoxication.

The mental health practitioner and psychiatrist tell Kieron that their aim is to develop a two-stage treatment plan, to help him at the festival and then when he returns home. The psychiatrist shares with Kieron her provisional formulation of social anxiety with secondary depressive symptoms, made worse by transition to adulthood. She explains how psychological treatment is likely to help him. He agrees to the psychiatrist writing to his GP, with a summary of her assessment and a recommendation for cognitive–behavioural therapy. They also talk through his plans for finding work. The mental health practitioner contacts the mental health crisis service in Kieron's home town, to find out what help is available locally, and then discusses with him short-term strategies to manage social anxiety for the remainder of the festival.

Kieron becomes noticeably more positive and no longer feels suicidal. The option of returning home early is raised and he decides against it: the headline act on the main stage that night is one of his favourites. He saves the phone number of his local mental health crisis team in his phone and agrees to them phoning him at home the following evening. He is glad of the offer to return to the festival mental health team premises if needed.

MCQ answers
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would be likely to have recovered by the time they had been conveyed to a hospital.

The MCA is applied in such circumstances, with the lead clinician in the case making a best interests decision, in accordance with the Act and its Code of Practice (Department for Constitutional Affairs 2007). The management of any patient lacking capacity is supported by an FMS procedural document based on national guidance concerning circumstances that might constitute a deprivation of liberty (Law Society 2015). These include continuous and intense restraint being required for more than 30 min or the patient being under continuous supervision for more than 4 h, with a plan to prevent departure from the healthcare facility should the patient attempt this. This guidance is not prescriptive and its primary purpose is to trigger a multidisciplinary review involving the psychiatrist, other senior FMS staff and, when available, friends or family of the patient. The review should ensure appropriate application of the MCA and MHA, taking into account the specific circumstances of the case. Options to be considered are listed in Box 4.

Safeguarding of children

A person with parental authority is contacted, or the duty social work team involved, in all cases involving children younger than 16 years. The same action is considered for patients aged 16 and 17 who do not follow advice to involve their parents in decisions about treatment and whether to remain at the festival. A breach of confidentiality is more likely to be justified in cases involving younger age, lack of maturity or mental capacity, complex decisions, significant risk of harm and refusal of treatment (Hawkins 2011).

There have been occasional presentations to the mental health team of people temporarily unfit to look after children in their care. In all such cases, there have been other adults able to take over the care of the children and a social worker from the local duty team has been involved.

Conclusions

Festival psychiatry is a challenging but rewarding area of clinical practice. Practical limitations, inherent in the provision of care on a temporary site, are offset by the benefits of cohesive multidisciplinary and multi-agency working. Services have been developed over many years within a robust clinical governance framework that promotes high-quality care. Clinical presentations are many and varied, with use of mental health law often necessary, and the vast majority of patients are managed on the festival site without the need to refer to local healthcare services.

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MCQs

Select the single best option for each question stem

1 **In Mark's case (Box 5), management would not have been altered by:**

a a history of psychosis
b vomiting
c muscle cramps
d comorbid alcohol intoxication
e availability of oral haloperidol.

2 **In Kieron's case (Box 6):**

a advice regarding ongoing antidepressant treatment is not the role of a festival psychiatrist
b treatment with a benzodiazepine should not be offered
c covert substance misuse is a likely diagnosis
d a provisional diagnosis of anxious personality disorder would be appropriate
e attendance at a festival excludes a diagnosis of agoraphobia.

3 **When providing festival psychiatric services:**

a there is no advantage in psychiatrists being approved under section 12 of the Mental Health Act
b creating a low-stimulus environment can be therapeutic in itself
c it is safer if psychiatric and general medical care are provided at facilities some distance apart
d liaison with local police and mental health services before the festival is seldom needed
e psychiatrists should only be involved in the care of patients who require prescription of psychotropic drugs or use of the Mental Health Act.

4 **Regarding clinical presentations at music festivals:**

a panic attacks are a recognised reason for presentation
b personality disorder is more prevalent among people who attend music festivals than those who do not
c depressive illness is common
d intoxication solely with alcohol frequently results in a need for psychiatric monitoring
e almost all young people attending festivals take illicit drugs.

5 **Clinicians using the Mental Capacity Act at festivals should:**

a only do so if no approved mental health professional is available
b consider whether a deprivation of liberty is likely to occur only after a patient has been under continuous supervision for at least 4 h
c ignore the concept of 'best interests' if the patient is a danger to others
d always arrange a Mental Health Act assessment if medication is needed for the treatment of mental disorder
e use the powers of the Act to convey the patient to a local hospital if acute hyponatraemia is suspected.