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PRACTICE

PRACTICE POINTER

Assessing an acutely disturbed person in the community

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What you need to know

- Attempt to de-escalate the situation: listen, acknowledge the person's feelings, reassure them that you wish to help, offer a quiet space to talk, a drink, and time to speak and be listened to
- In rare circumstances, where there is an imminent physical risk to the person or others, use internal alarms to alert the rest of the practice, contact police, and consider evacuating the area
- Check for the presence of physical and mental health comorbidities, the role of recreational drugs or alcohol, and acute life stressors (relationships, housing, finances, access to services)
- Establish any risk factors, such as a history of aggression, self harm, or suicide attempts, recent psychiatric admission, or a forensic history
- If the situation cannot be safely de-escalated then Section 136 (S136) of the Mental Health Act is a police power in the United Kingdom to remove someone to a place of safety for assessment and it can now be used in any part of a general practice or community clinic

You are urgently called to reception where a 25 year old man is shouting about the building having been taken over by demons. He appears distressed and is not responding to attempts by reception staff to communicate with him. He shouts about his neighbours, that he needs to "sort them out." You see from his notes he has a history of psychotic episodes.

It can be difficult to know what to do when a person in severe psychological distress presents to a general practice or community clinic, particularly if they are behaving aggressively, or if they are refusing help. The person may be experiencing a deterioration in their mental health, such as a psychotic episode, or it may be related to substance use or acute social stressors. Most patients who are acutely disturbed present no danger to others, however situations can evolve rapidly. Frontline staff need to know how to call for help, how to assess and manage physical risk, and how to de-escalate such situations.

This Practice Pointer article offers advice about an initial approach to a person who is acutely disturbed in a community setting, particularly focusing on those presenting with a suspected psychotic episode. Recently, the Mental Health Act in England and Wales has undergone some important changes, but the principles outlined here are generalisable to other settings.

How to approach and assess the person?

There is limited evidence about the frequency, cause, or management of severe behavioural disturbance in people presenting in community settings. These suggested approaches are based on accepted clinical practice and experience of authors.

Immediate actions

Use non-aggressive verbal and non-verbal communication, while monitoring the situation for potential risks to the person and to staff and other patients in the waiting area.[1]

Communication

- Focus on the person, listen to what they are saying
- Ask their name
- Present a calm demeanour
- Consider the potential physical risk to staff and patients and take action if the risk is high, by
  - using silent internal alarms to attract help;
  - considering evacuation of patients or staff at risk;
  - having other staff call the police (ideally out of earshot of the distressed person);
- Alert clinical staff that a rapid assessment of the person may be needed.

Safety

- Find a safe quiet area for the person to wait
- Get something for the person to drink

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- Have someone sit with the person if it is safe to do so.

Positive actions

- Actively listen to the person and use summarising statements to show that you are listening
- Identify why they have presented here and now
- Be attentive to cues mentioned by the person
- Acknowledge the person's feelings and distress and build trust by reassuring the person that you wish to help, following the principles of patient centred care.[2]

Involve others

- Involve anyone at the practice who knows, and is trusted by, the person
- See if a relative/friend/carer can attend or provide collateral information
- Ask other staff members to access the clinical notes and provide a summary for the assessing clinician quickly.

Community settings should have (ideally silent) emergency communication systems to call for help from other staff. Encourage staff to call senior managers and clinicians for support in such situations, so that non-clinical and uninvolved clinical staff can manage the ongoing function of the reception and clinical areas. Intervening early and decisively could prevent a more extreme reaction later.

Clinical assessment

An acutely disturbed person needs urgent assessment. At the end of this initial assessment the clinician will need to decide how urgently the person needs to be assessed by a medical or psychiatric team and whether it is necessary to seek support from the police or emergency services to convey the patient to a safe place for assessment. Aim to form a differential diagnosis, assess capacity, complete a brief risk assessment, and develop a provisional management plan.

Differential diagnosis

Consider whether any of the following factors are contributing to the presentation:

- A reaction to stressors (relationships, housing, finances, access to services)
  You might ask
  – what are the person's main concerns?
  – has anything happened to precipitate this presentation?
- Intoxication with, or withdrawal from, alcohol or recreational drugs
  You might consider whether this is intoxication or withdrawal, either alone or with psychological comorbidities
- A history of medication use
  You might ask if the person has been taking the medication as prescribed
- A first episode or relapsing psychosis
  You might ask or investigate
  – is there a history of mental health problems (diagnosis, severity, admissions, treatment)?
  – when, how, and why symptoms may have changed?
  – has there been any history of recent contact with emergency and/or psychiatric services?
- Other organic causes (adverse medication reactions, infections, neurological illnesses, metabolic and endocrine disorders)
- Other psychiatric comorbidities, eg, acute stress reaction in the context of an emotionally unstable or dissocial personality disorder.

Prevalence data on presentations of disturbed persons to primary care are not available. Acute psychological stressors and factors related to substance abuse may be common causes, and if there is judged to be no acute risk to practice staff and patients, would normally be managed by primary care clinicians, using non-acute established pathways. People seeking drugs may have a history of dependence and may show signs of withdrawal. It is very rare for such patients to threaten staff or patients, but if so, then the practice can alert the police, as for any patient who is being intimidating in the context of intoxication alone.

It can be more challenging to manage and arrange urgent support for an acutely psychotic patient in a community setting.

Psychotic illness

Psychotic illnesses are common; with an annual prevalence of an active psychotic disorder of 4 in 1000 adults.[3] It is not known how many people present in primary care or the community when experiencing an acute psychotic episode. However, rates of patients detained by the police on S136 in the UK have risen, which might suggest an increase in acutely disturbed presentations in community settings. Figures from NHS digital 2015-16 show a rise of 18% from the previous year, to 22 965.[4] During this period, 17.8% of people detained on S136 subsequently went on to be detained under Section 2 or Section 3.[4] (box 3).

Box 3: Different types of Mental Health Act sections

The person is suffering from a mental disorder of a nature (chronicity, prognosis, previous response to treatment) and/or degree (current manifestation of the illness, eg, severity of current symptoms, impact on functioning etc.) that warrants

Section 2

Detention in hospital for assessment for up to 28 days. The person ought to be detained in the interests of their own health and/or safety and/or the protection of others.

Requires two doctors, one of whom must be Section 12 (2) approved (having received training in the application of the Mental Health Act. This is usually a psychiatrist or a GP with an interest in mental health) to make recommendations and then the application is made by an approved mental health professional.

Section 3

Medical treatment (up to six months) in hospital. It is necessary for the health or safety of the person or for the protection of other persons that they should receive such treatment which cannot be provided unless the person is detained, and appropriate treatment is available.

Requires two doctors, one of whom must be S12 (2) approved to make recommendations and then the application is made by an approved mental health professional. In this instance the approved mental health professional must consult, if practicable, the nearest relative and the admission cannot proceed if the nearest relative objects.

Section 4

An emergency application for detention which can be made on the basis of a single medical recommendation (not needing S12 approval) with a recommendation from an approved mental health professional or, in exceptional circumstances, the nearest relative (as defined by the Mental Health Act S26). The criteria for S2 need to be met and the detention is required as a matter of urgency. A S4 lasts for 72 hours.

Section 135 (1)

Gives the police the power to remove a person from a dwelling (ie, any private property) if it is considered they have a mental disorder and that they may be in need of care and attention for this. With the agreement of the person they can be assessed at the dwelling or removed to the place of safety for the assessment to take place there. It lasts up to 24 hours and requires a warrant to have first been obtained from a magistrates' court.

Section 136

Gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder and are in need of care or control, to a place of safety. It lasts up to 24 hours.

Section 5(2)

A temporary hold of a patient already receiving treatment in a hospital, applied by any doctor for up to 72 hours.

A person experiencing a psychotic episode will often lack insight[5] and therefore may not present asking for help. If services are alerted by family or friends asking for help, then a planned response by primary care or psychiatry teams (including domiciliary visits) may be most appropriate. Sometimes relatives may persuade a person to go to the GP or the emergency department. However, in an acute presentation, with no warning, there are different options for managing the situation depending on where the patient is, and whether they are known to mental health services already.

In a suspected psychotic episode, assess for the presence of delusions, hallucinations, and disordered thinking or speech. This includes assessing the content and nature of the patient's beliefs, and the impact of those beliefs on their past and potential actions. Usually, most assessments of a person at first presentation would also include questioning the validity of their beliefs, but this may not be appropriate in an acute presentation in a community setting.[6]

Risk assessment

Carry out a brief assessment of the risk of harm the patient might pose to themselves or others. Box 1 outlines red flag symptoms and signs that might increase risk.

Box 1: Risk of harm to self or others when seeing psychiatric emergencies[7]

- Recent (within last 2 weeks) discharge from inpatient services[8]
- History of self harm or suicide attempts, hopelessness, suicidal ideation/plan
- Current alcohol or drug misuse
- Notable forensic history (such as serious assault)
- Delusions focussing on an individual
- History of carrying weapons

Key risks include self harm, accidental injury, vulnerability to assault from others, and harm to others.

In known patients, any serious risk history should be known to the practice.

Referral

If you suspect an underlying mental health cause and the patient calms, consider contacting local psychiatry services, who can provide the person's recent history (in some areas psychiatry electronic records are available to primary care). Local psychiatry services may offer urgent assessment. If there are any concerns about physical health problems (such as alcohol withdrawal) then assessment at an emergency department may be most appropriate. Mental health services available could be the local community mental health team/home treatment team/liaison psychiatry/street triage/single point of access service (depending on local arrangements). If the person is a known patient, they may have a "crisis plan" or advanced directive in their records, which will inform care planning.

Ask the person:

- Do they have a crisis plan?
- Would they agree to be seen by the specialist mental health team, for example at the local emergency department, street triage, or the local crisis team, depending on local options?
- Do they have a care coordinator that they would like to see?

What options are available if the person refuses to be assessed?

No immediate risk

If the assessment suggests there are no immediate risks and the patient calms down, but the initial assessment suggests that there is mental disorder and the patient is still refusing immediate help, then a Mental Health Act assessment can sometimes be organised, depending on local protocols. In the UK this would be a Section 4, but is more likely to be a Section 2 or a Section 3 organised with the local approved mental health professional and police over the following few days (box 3) (in locations where demand is high and resources are low there can be longer waiting times for community Mental Health Act assessments).

A Mental Health Act assessment can take time to organise, and most practices are not resourced to manage a disturbed person safely in the meantime. In this case the best option might be for the person to be seen in the emergency department of a hospital if they agree to go, while acknowledging that the security and environment may not be ideal. It is a matter of determining, as best as is practicable, what the safest option for the person might be.

In some situations it may be better, if safe, for the person to return home and wait for input from the mental health team you have contacted.

Immediate risk—call the police

If a person is unwilling to engage in any form of assessment at the surgery, is refusing to go to another setting, and you have immediate concerns about risk to self or others, then it may be necessary to call the police.

The police can use their powers under S136 of the Mental Health Act. S136 is a police power to remove someone they feel is in immediate need of care or control to a place of safety, for the purpose of assessment. There will be designated places of safety locally, which are usually based in psychiatric hospitals. Emergency departments can also be used. Recent changes to S136 clarify the use of police powers in such a situation.[9]

Removal from the statute of the link between the operation of S136 and "a place to which the public have access" has clarified some previously grey areas. There had been some debate about whether S136 powers could be used, for example, in treatment areas of the emergency department or GP consulting rooms. It is now clear that police will be able to exercise these powers in these settings if the criteria to do so are fulfilled. Police can use S136 powers in all areas of a GP practice. They can only not use S136 powers in a private residence or the private garden or buildings associated with a private residence. For a summary of recent changes to S136 see box 2.

Box 2: Changes to the S136 in the Police and Crime Act 2017

Police should consult a registered medical practitioner, a registered nurse, or an approved mental health professional, if practicable, before using S136.

S136 can be used in any place other than a private dwelling or its private garden. The new legislation has removed reference to a place to which the public have access—so these powers can be used in all areas of a GP practice.

A child may not, under any circumstances, be removed to a police station as a place of safety.

Police stations can only be used as a place of safety for adults in limited circumstances (imminent risk of serious injury or death, when nowhere else can reasonably manage the risk). Given that a person is in a mental health crisis and there may be an accompanying physical disorder including intoxication with alcohol and drugs, it is recommended that the person be assessed in a healthcare setting.

There is a reduction in the permitted period of detention from 72 hours to 24 hours with the possibility of a 12 hour extension (if not practicable to complete the assessment for example in 24 hours for example because of intoxication).

If the person leaves the practice before anything can be organised then the police and the patient's family can be alerted if concerns about risk remain. Alternatively, the local mental health services could be contacted to ask for an urgent assessment, depending on local systems.

How to involve carers and relatives

The person may make it clear that they don't want you to discuss their care with their family, which can be difficult. In this situation, if your considered assessment is that the patient lacks capacity to make this decision, confidentiality may be breached if failure to do so may expose the person or others to a risk or if you judge it is in the person's best interests.[10] If the person has capacity and refuses to consent to information being shared, then confidentiality maybe breached if certain conditions are met, such as risk to carers, relatives, or others.[11]

Importantly, carers and relatives can always give information to clinicians, with no release of information by clinicians to them.

If the person agrees, carers can give collateral history and support the person during the assessment. Carers may need support themselves—guide them towards local carer support groups if interested.

If a patient is placed on S136 in the practice, inform any involved carer or family member as soon as possible.

Post-presentation follow-up

Care governance

Review the care provided in the acute setting soon after the incident, and identify any gaps in facilities, staffing, or staff training, which could improve future care and dignity for similarly distressed patients. Staff members can find situations like this quite distressing—offer an opportunity to speak individually to the practice manager or other appropriate senior team member to check whether they need support.

Communication between teams

The mental health team should inform the primary care team of the consequences of assessment (use of any section, admission, treatment, home treatment team, routine community follow-up, crisis plan).

Patient follow-up

Mental health

It is good practice for the GP to contact patients after discharge from inpatient or other care, to invite them for a non-urgent face to face, or telephone, discussion of progress. This would provide an opportunity for patients to discuss their crisis plan if presenting to primary care in future, and how events were managed when they presented in crisis.

Physical health

Patients with serious mental illness have 15-20 years reduced life expectancy[12] so it is useful to consider a physical health review (opportunistically or planned), including cardiovascular disease risk factors. Offer referral to the smoking cessation adviser. Arrange relevant blood tests or electrocardiogram as required by identified behavioural risks or medication review.

Crisis plan and relapse indicators

Review the patient's "crisis plan" (or recommend this is discussed with a care coordinator). Discuss relapse indicators (or early signs of relapse) and set out what might be done if there should be a relapse in future, including information about medication and who to contact in an emergency.

Patient perspective

I am a dentist who has been diagnosed with bipolar disorder. I have been unable to work for the last four years due to my mental health difficulties. This is basically due to the highs I experience. I have needed to complete a year without admissions to retain my registration. Unfortunately, every year I end up being sectioned, often having been brought in at first on Section 136.

During my "highs" I am in spiritual bliss. But I'm vulnerable to exploitation as I freely give away whatever I have. The highs have completely destroyed my career and taken years away from me due to lengthy detentions in hospital, including in a psychiatric intensive care unit (PICU).

When asked to give an account of being sectioned by the police (Section 136) it conjures up mixed feelings. I will have been riding a manic high and the police have brought the party to a close. This is always upsetting, but how the police handle a situation can influence the level of psychotic symptoms evoked. A gentle approach results in much better compliance and cooperation. For example, when police have been hasty to use hand cuffs, I—already in a heightened state—have exploded into rage. This leads to a vicious circle with a more aggressive response by the police. The tighter the cuffs, the more volatile my state. The police now will have every reason to relay this information to the psych team who will steer me towards a PICU detention.

The 136 Suite can be rather disturbing. I have reached highs which give me the feeling of freedom from any ties…. Then I'm locked in a room. It's a tough transition, one I have had to face multiple times. Waiting for the assessment is frustrating. I want to be seen hastily and move onto a ward, but I've had waits of nine hours at times. This has been without medication, which I've desperately wanted to take the edge off.

When the assessment does come it can feel like the team is looking for reasons to section rather than explore other options. This could be much better explained to me, even if I don't seem to be receptive at the time. Generally, staff dealing with my crisis have acted well. The outcome may not have been what I had hoped for, but action was needed.

How patients were involved in the creation of this article

A person who has had experience of being sectioned commented on and approved the final draft of the article and has provided a patient account.

Education into practice

Think about the last time you assessed a patient who was acutely distressed. What aspects of the risk assessment might you do differently? Did you feel confident about the legal framework or services available for getting the person additional physical and mental health support?

What training might be useful for staff in your setting to increase confidence when assessing a patient who is acutely distressed?

How might the recent changes to Section 136 affect your practice?

How this article was made

Authors AO, SK, and JC have been involved in writing the 2018 Royal College of Psychiatrists guidelines (FAQs) regarding the recent changes to Section 136 and Section 135 of the Mental Health Act. JI provided a GP partner perspective and a patient with experience of being sectioned gave a view from a patient's perspective.

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