Introduction to Psychiatry

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Summary

The following are the broad headings of a standard psychiatric assessment, which are discussed in detail later in the chapter. Special considerations for specific patient groups (children, older people, etc.) are discussed at the beginning of relevant chapters.

Psychiatric history

- Patient's personal details
- Presenting complaint
- History of presenting complaint
- Past psychiatric history
- Past medical history
- Drug history
- Family history
- Personal history:
  - Childhood
  - School
  - Occupations
  - Psychosexual history
  - Alcohol and substance use
  - Forensic history
  - Social situation
- Premorbid personality

Mental state examination

- Appearance and behaviour
- Speech
- Mood
- Thought
- Perception
- Cognition
- Insight

Signs and symptoms

Affect is the observable behaviour of a subjectively experienced emotion. It is variable over time (in comparison to mood which is a pervasive and sustained emotional state). Affect may be:

- *blunted* – lack of appropriate emotional response to events
- *flat* – absence of expression of affect
- *inappropriate* – affect is inappropriate to the thought or speech it accompanies
- *labile* – rapid changes in affect.

Anxiety is a feeling of apprehension, uneasiness or tension. It is accompanied by somatic sensations including sweating, palpitations and shortness of breath. Anxiety may be free-floating (pervasive) or related to a specific fear (phobic).

Compulsions are stereotyped acts, recognised as excessive, unreasonable or exaggerated. If the patient tries to resist doing them, there is a sense of mounting tension that can be immediately relieved by yielding to the compulsion. Often involve:

- cleaning
- checking
- counting
- hoarding.

Delusions are abnormal beliefs which are held with absolute certainty. They are based on incorrect inferences about external reality and are firmly held despite proof or evidence to the contrary. They are not beliefs which can be understood as part of their cultural or religious background. The beliefs are usually but not always false – for example, the patient's spouse may actually be having an affair. It is the abnormal thought processes that define a delusion, not whether the belief is true.
Delusions may be classified as primary or secondary.

- **Primary delusions** do not have any identifiable connection with previous events and are a direct result of the psychopathology. Types of primary delusion are:
  - *autochthonous* – 'out of the blue', fully formed beliefs
  - *delusional memory* – arising from a memory
  - *delusional mood* – arising from a period of anticipatory anxiety and the sense that something was about to happen
  - *delusional perception* – an abnormal belief arising from a normal perception (e.g. the traffic lights turn red and the patient realizes that is a sign they are the next Messiah).
- **Secondary delusions** arise out of another primary psychiatric symptom (e.g. low mood) and are understandable in the context. They are a product of an attempt to understand the primary morbid experience.

Common types of delusion include the following.

- *Persecutory* – being conspired against, attacked or persecuted.
- *Grandiose* – inflated self-worth, special powers or abilities, relationships with important and special people, having a mission.
- *Reference* – events have a particular and unusual significance for the patient, they are being referred to on television and in the newspapers.
- *Delusions of control (passivity phenomena)* – being controlled by an external agent:
  - emotions
  - impulses
  - actions
  - somatic passivity (bodily sensations).

- *Thought interference (passivity phenomena)* – thoughts are controlled by an external agency:
  - thought withdrawal
  - thought broadcast
  - thought insertion.
- *Misidentification* – certain individuals are not who they appear to be. Familiar people have been replaced with outwardly identical strangers (Capgras syndrome) or strangers are really familiar people (Fregoli syndrome).
- *Guilt* – believe they deserve punishment.
- *Nihilistic* – they have died or no longer exist or that the world has ended.
- *Hypochondriacal* – believe they have a serious physical illness.
- *Jealousy* – partner is being unfaithful (Othello syndrome).
- *Love* – another person, usually of higher status, is deeply in love with them (de Clerambault syndrome).
- *Infestation* – their skin is infested with multiple insects or parasites (Ekbom syndrome).

Delusions may be mood congruent, e.g. grandiose in elated mood states and nihilistic in depressed mood states, or mood incongruent, e.g. grandiose in depressed states.

Depressed mood is the core feature of a depressive illness. Patients describe a pervasive unhappiness, being unable to feel happy, hopelessness, helplessness and negative thoughts about themselves, the world and the future. Other features of a depressive illness are discussed in the relevant section.

Elevated mood is the core feature of a manic illness. Patients describe feeling very happy, being positive about everything, feeling indestructible, feeling more creative, being able to think more quickly and achieve more tasks than usual. Other features of a manic illness are discussed in the relevant section.

Formal thought disorder refers to an abnormality of the form of thought.

- *Circumstantiality* – irrelevant and unnecessary details are incorporated into the thinking, meaning that the goal of the thought is reached very slowly.
- *Flight of ideas* – accelerated thoughts with abrupt changes to related thoughts. The connections between the thoughts may be based, for example, on puns, rhyming words or alliteration.
- *Loosening of associations* – lack of meaningful connection between thoughts:
  - derailment – thought derails onto a subsidiary thought
  - drivelling – disordered mixture of the constituent parts of one thought
  - fusion – two or more unrelated concepts are brought together
  - omission – part of a thought is omitted
  - substitution – a thought is substituted by a subsidiary thought.
- *Neologism* – a new word constructed by the patient or an existing word used in a new way.

Hallucinations are perceptions without the corresponding external object. The subjective experience is a normal perception in that sensory modality (i.e. voices sound like 'real' voices). A true hallucination will be perceived in external space and be outside conscious control.

- *Auditory:*
  - second-person – voices directly addressing the patient (e.g. 'you are useless')
  - third-person – two or more voices discussing the patient (e.g. 'he's very powerful')
  - thought echo – voices echo thoughts before or after they happen
  - running commentary – voices comment on action (e.g. 'he's going out of the door now').

Signs and symptoms (continued)

- *Visual* – e.g. small figures seen in delirium.
- *Olfactory* – usually an unpleasant smell.
- *Gustatory* – commonly a feeling that something tastes differently and this is often interpreted as being the result of poisoning.
- *Somatic* – e.g. sensation of insects under skin or movement of joints.

Illusions are false perceptions of a real external stimulus. There are three types:

- *affect* – during heightened emotion (e.g. when walking alone on a dark night, seeing a shadow as an attacker)
- *completion* – 'filling in' of presumed missing parts of an image (e.g. optical illusions)
- *pareidolic* – produced when experiencing a poorly defined stimulus (e.g. seeing faces in the clouds).

Obsessions may be persistent thoughts, images, doubts or impulses. They are acknowledged as originating in the mind and are repetitive and intrusive. The patient tries to resist them. The obsessions cause distress and interfere with functioning. Common content includes:

- contamination
- bodily fears
- aggression
- orderliness/symmetry.

Overvalued ideas are an unreasonable and sustained intense preoccupation. It is not of delusional intensity (the person can acknowledge that it is possible the belief may not be true). The ideas can be understood but are incorrect and can come to dominate the person's life.

Pseudo-hallucinations are a form of imagery arising in the subjective inner space of the mind and not perceived as part of the external world. They do not have the same quality as normal perceptions. They can occur in any sensory modality but are most commonly auditory.

Psychiatric history

Patient's personal details

- Name
- Age
- Gender
- Marital status
- Occupation
- Religion/ethnic group

Presenting complaint

- Document this in the patient's own words.
- Document how long the patient has had the problem, e.g. 'feeling low for the last few months'.
- Use open-ended questions to elicit these, e.g. 'Can you tell me about the problems that brought you here?'.
- Let the patient speak uninterrupted for the first few minutes before continuing questioning.

History of presenting complaint

- When did the problem start?
- Has it changed over time? If so, how?
- Were there any precipitating events, e.g. bereavement, divorce?
- Any psychological/drug treatments for the current problem? If so, did they help?
- Screen for any other problems. All patients should be asked about suicidal ideation, depression, anxiety, obsessional behaviour and psychosis.

Past psychiatric history

- Have they seen a psychiatrist before?
- Have they been treated by their GP for any mental health problems?
- Have they been treated in hospital before?
- Were they detained under mental health legislation?
- Are there any previous risk behaviours (deliberate self-harm, violence, aggression, etc.) related to their previous mental health problems?

Past medical history

- Enquiry regarding any significant illnesses, operations or accidents.

Drug history

- Do they take any regular medication?
- What medication have they taken previously for their mental health and was it effective?

Family history

- Is there a family history of mental illness?
- Collect information about parents, siblings and other significant relatives.
- Enquire about age, occupation, social circumstances and quality of the relationship with the patient.
- Make a genogram (family tree) of the information.

Personal history

- *Childhood* – birth history (difficulties, prematurity); developmental milestones, delay in particular; description of early childhood; family and home atmosphere.

Psychiatric history (continued)

- *School* – leaving age; any truancy or school refusal, bullying; relationships with peers, teachers; exams taken and qualifications, further education.
- *Occupations* – list all jobs and duration of employment, reasons for leaving and any periods of unemployment.
- *Psychosexual history* – current relationship if any, sexual orientation, any sexual difficulties, first sexual experience, any sexual abuse, past significant relationships – reasons why they ended.
- *Alcohol and substance use* – alcohol, tobacco and illicit drugs; record amount, e.g. units of alcohol per week; current and previous use; patterns of use; symptoms/signs of dependency and withdrawal; associated problems, e.g. financial difficulties.
- *Forensic history* – record all offences whether convicted or not (especially note violent crimes, sexual crimes and persistent offending).
- *Social situation* – type of housing, who else is at home; financial circumstances including income, benefits, debts; social support – friends, relatives, social services.

Premorbid personality

- Difficult to assess in a short interview. Focus on consistent patterns of behaviour throughout life. This part should include an account from an informant, as no individual can objectively describe their own personality. Useful questions include 'How would you describe yourself when well?' and 'How would others describe you?'.
- *Areas to include* – attitudes to others in relationships; attitudes to self; predominant mood; leisure activities and interests; reaction to stress, coping mechanisms.

Mental state examination

Appearance and behaviour

- *Dress, self-care* – e.g. bright colours and flamboyant clothing may be seen in mania, self-neglect in depression.
- *Behaviour during the interview* – restlessness, tearfulness, eye contact, irritability, appropriateness, distractibility.
- *Psychomotor* – poverty of movement, stereotypes, rituals, other abnormal movements.
- *Level of rapport* established during interview.

Speech

- *Rate* – slow/retarded, pressured/uninterruptible.
- *Tone* – normal, monotone or excessive intonation.
- *Volume* – whisper, quiet, loud.
- *Content* – monosyllabic, spontaneous or only in answer to questions.
- Dysphasia or dysarthria.

Mood

- *Objectively* – your impression – depressed, elated, euthymic, blunted or flattened, anxious.
- *Subjectively* – how the patient reports prevailing mood – depressed, elated.

It is usual to also record any thoughts of self-harm or suicide here.

Thought

- Formal thought disorder
- Passivity of thought
- Overvalued ideas
- Obsessions, compulsions, ruminations
- Beck's cognitive triad – negative views of self, the world and the future
- Delusions

Perception

- *Sensory distortions* – increase in sound or colour sensitivity.
- *Illusions* – a misinterpretation of normal stimuli.
- *Hallucinations* – false perceptions in the absence of any stimulus.

Cognition

- Consciousness, orientation, concentration, attention.
- Memory: the Mini-Mental State Examination (MMSE) is a widely used bedside test which screens for cognitive problems. It includes elements such as orientation, attention, short-term memory, naming objects and following verbal and written commands. A score out of 30 is obtained, with a score of less than 25 being suggestive of dementia. The MMSE does not assess frontal lobe function and this will need to be considered by other tests.

Insight

- Does the patient believe they are unwell?
- What do they think is causing it?
- Are they willing to accept help?

Mental state examination (continued)

Formulation

- *Summary* – aim to give a very short précis of the relevant points of the case. Include the following: patient's demographic details, relevant background information, chronological presenting symptoms, relevant mental state examination findings.
- *Differential diagnosis* – it is important not to forget organic causes, as these can be easily reversible and require different management. Simple blood tests are important, for example:
  - anaemia causes fatigue which is also found in depression
  - thyroid abnormalities can mimic depression or mania
  - calcium abnormalities can cause depression
  - renal failure and liver failure can cause delirium.
- *Aetiology* – consider biological, psychological and social issues (use the grid below to fit these together).

Factors	Biological	Psychological	Social
Predisposing (what made this problem likely?)			
Precipitating (what triggered it?)			
Perpetuating (why is it still going on?)			

- Management plan:
  - need for history from other informants
  - physical examination
  - blood tests and other investigations
  - risk assessment
  - psychological assessment
  - OT assessment
  - consideration of social circumstances and accommodation
  - psychological therapies
  - medication
  - involvement of MDT
  - use of relevant legislation.
- Prognosis.

Classification systems for mental disorders

International classification of diseases (ICD-10)

- International classification system
- Published by the World Health Organization (WHO)
- Covers all physical and mental illnesses and disorders
- Psychiatric disorders covered in Chapter V of ICD-10
- Categorical classification of diagnosis
- Single axis of diagnosis using the concept of co-morbidities
- Used more commonly in clinical settings within the UK

Diagnostic and statistical manual of mental disorders (DSM-IV)

- National classification system used in the United States of America
- Developed by the American Psychiatric Association
- Exclusively covers psychiatric disorders
- Classification characterised by operational diagnosis
- Multiaxial system of diagnosis which includes:
  - Axis I – Clinical syndromes
  - Axis II – Developmental disorders and personality disorders
  - Axis III – General medical conditions
  - Axis IV – Psychosocial and environmental problems
  - Axis V – Global assessment of function
- Used more commonly in the USA but less so in the UK

Assessment of suicide risk

All patients being evaluated psychiatrically should be assessed for suicide risk. Never be afraid to ask about suicide – simply by asking, you will not increase the likelihood of a patient committing suicide and remember that identifying a suicide risk can prevent a patient committing suicide. Make sure the setting is calm, quiet and private. Establish a good rapport – use a calm, understanding and sympathetic approach.

Suicide risk is increased by a sense of hopelessness, the presence of psychiatric and medical illnesses, the presence of recurring suicidal thoughts, recent stressful events (e.g. loss of job or bereavement) and previous attempts at suicide. The risk is increased if the suicidal thoughts have led to formulating a plan as to how to go about it. A lack of social support also contributes to an increased risk, as does a lack of strong 'preventing' factors such as religious belief or children to look after. These factors must be asked about in order to assess the patient's suicide risk. Below are some suggested questions that could be used for assessing suicide risk.

Eliciting a sense of hopelessness

- Do you still get pleasure out of life?
- How do you feel about the future?
- Does life seem worth living?
- Are you able to face each day?
- Do you ever wish you would not wake up?
- Do you find there are things to live for? Tell me about them.

Suicidal thoughts

- Have you ever thought of ending it all?
- Are you able to resist the thoughts?
- How do you feel about these thoughts?
- Have you ever thought about methods of suicide?
- Have you ever made any plans?
- Have you started to put these plans into action?

Previous attempts

- Have you ever tried anything before? Can you tell me about it?

Social support

- Have you ever told anyone before about how you feel?
- Do you have someone to confide in, close family or friends?
- Who do you live with – do you have company at home?

Identifying stressors that increase the risk

- Is there something in particular that is making you feel worse? Can you tell me about it?

Preventing factors

- What might prevent you from carrying out any plans?

Health problems

- Do you know if you are suffering from any mental health problems?
- Do you have any other health problems that are bothering you?

Deliberate self-harm

DEFINITION Intentional self-inflicted injury/harm without a fatal outcome.

AETIOLOGY

- 'Cry for help' – to obtain relief, to escape a situation, to seek attention or to make someone feel guilty
- Impulsivity
- Poor coping strategies
- Self-punishment
- Failed suicide attempt

ASSOCIATIONS/RISK FACTORS

- Single/divorced
- Lower social classes
- Previous history of child abuse
- Unemployment
- Recent stressful event, e.g. loss of loved one, being in trouble with the law
- Borderline personality disorder
- Depression
- Substance misuse

EPIDEMIOLOGY Incidence of 3 per 1000 in UK but this is probably an underestimate. More prevalent in lower social classes and those living in crowded urban areas. More common in women and those under 35 years.

HISTORY This should focus on obtaining a clear account of events and intentions in order to undertake a risk assessment of future risk of self-harm and suicide.

Indicators of serious suicidal intent

- A planned and premeditated attempt, e.g. 'I have been collecting the packets of paracetamol for weeks, I have been buying a packet a week with my shopping'.
- Attempt carried out in isolation and precautions taken to avoid discovery, e.g. 'I locked my door so no one could get in'.
- Final acts in anticipation of death, e.g. 'I had written suicide notes and posted them to all my friends and family'.
- Violent, dangerous methods, e.g. 'I knew that if I tried to cut the veins in my neck, it would be more effective than slitting my wrists'.
- Person thought the act would be final and irreversible, e.g. 'I thought that 10 paracetamol would be enough to kill me'
- They did not seek help after the act, e.g. 'I am angry that my flatmate came home unexpectedly and called the ambulance'.
- Person regrets surviving the attempt, e.g. 'I wish I'd made a better job of it'.
- Numerous previous attempts, e.g. 'This is the third time I have tried to kill myself; I am a failure, I can't even do that right'.

EXAMINATION Mental state examination may reveal a psychiatric disorder, which is of crucial importance in determining future risk and should be suitably managed once identified.

INVESTIGATIONS None specifically.

MANAGEMENT

- Treat as medically appropriate.
- Full assessment – assess risk and need for hospital admission. Use MHA if necessary.
- Treatment of underlying psychiatric disorders.

Deliberate self-harm (continued)

- A small minority of patients will present frequently with deliberate self-harm without suicidal intent. An individualised management plan should be agreed that does not reward maladaptive behaviours but provides appropriate support.

COMPLICATIONS Repeated self-harm, unintentional suicide, suicide.

PROGNOSIS One percent will commit suicide within the next 2 years. This means that this group is at 100 times greater risk of suicide than the general population. Hence the need for a psychiatric assessment following deliberate-self-harm.

Suicide

DEFINITION Intentional self-inflicted death. Not all suicide attempts result in death. It can be difficult to distinguish between those that were intended to be fatal and those that were acts of deliberate self-harm.

AETIOLOGY

- *Psychiatric disorders* (90% of those who commit suicide have a psychiatric disorder):
  - depression (15% of patients commit suicide)
  - schizophrenia (10% of patients commit suicide)
  - substance misuse
  - personality disorder
  - anorexia nervosa.
- *Medical disorders* – chronic pain and cancer patients.
- *Biochemical abnormalities* – studies of CSF and brain show reduced 5-HIAA.
- *Social factors* – loss of shared values and reduced social support.

ASSOCIATIONS/RISK FACTORS

- Previous deliberate self-harm
- *Age* – young men and elderly are at higher risk
- *Sex* – M > F
- Loss events (e.g. bereavement)
- Unemployment
- Living alone
- Single, divorced or widowed

EPIDEMIOLOGY Annual incidence in England and Wales is approximately 1 in 10,000; rates vary between countries. Highest rates in the elderly, although rates rising in young men. It is more common in men than women.

PREVENTION

- Individual level
  - Detection of people at risk of psychiatric disorders
  - Effective management of psychiatric disorders
- Population level
  - Reduce ease (e.g. smaller packets of paracetamol)
  - Provide support services (e.g. Samaritans)
  - Reduce stressors (e.g. reduce unemployment)
  - Reduce stigma of mental health (e.g mental health campaigns with MIND)

Multidisciplinary team

This is the team of professionals who are responsible for the long-term care of the patient. The advantage of working in this type of team is that all the patients' needs can be properly addressed and comprehensive care provided. Psychiatric patients benefit greatly from psychological and social input in addition to their medical care. Multidisciplinary teams (MDTs) operate on wards, in day hospitals and in the community. All members of the team will attend ward rounds and meetings concerning the patient.

Members of the MDT

- Psychiatrists
  - Assessment and diagnosis of mental illnesses
  - Decision making and liaison regarding management
  - Recommendations for detention under the Mental Health Act if required
  - Prescribing and monitoring of medication
  - Management of physical health problems
- Psychiatric nurse
  - Monitoring and observations of inpatients
  - Administration of medication
  - Involved in decision making about leave arrangements for detained patients
- Community psychiatric nurse
  - Monitoring of outpatients in the community
  - Visiting patients at home regularly to assess mental state and review progress
  - Giving depot injections
- Social worker
  - Involving the patient's family with their care
  - Finding appropriate accommodation
  - Assisting with other social issues, such as benefits
  - Assessments of vulnerable adults and child protection issues
- Occupational therapist
  - Helping people reach their maximum level of function and independence in all aspects of daily life
  - Assessment of activities of daily living
  - Developing skills to assist with attending courses or returning to employment
- Clinical psychologist
  - Assessment of patients' suitability for psychological treatment
  - Psychological assessments including intelligence tests and personality assessments
  - Psychological treatment of patients, for example cognitive behavioural therapy

Patient advocates are not members of the MDT but help the patients express their opinions and any concerns they may have. They may attend meetings with the patient to make requests on behalf of the patient.

Ethical issues

The practice of psychiatry requires detailed consideration of important ethical and legal issues. This is essential as psychiatric care often requires making decisions on behalf of patients or detaining and treating patients against their will. As this over-rides a patient's right to make their own decisions, it is crucial that this occurs within an ethical and legal framework. The relevant mental health legislation is discussed later in this section. The ethical principles are outlined below.

Respect for autonomy

Patients should be treated as rational autonomous agents who are allowed to make decisions regarding their treatments. From this principle, other requirements follow, including informed consent and confidentiality. Respect for a patient's autonomy assumes that they have the capacity to make rational choices. However, capacity can be impaired in both physical and mental illnesses. The assessment of capacity is an important skill for all doctors.

Beneficence

This is the requirement to do good and promote well-being. This should be the guiding principle of doctors' interactions with patients.

Non-maleficence

'First, do no harm.' This is difficult to separate from the principle of beneficence, as in almost all therapeutic decisions a judgement is made about the balance of benefits against the potential harm. A common example is the prescription of medication; consideration is given to the intended outcome of taking the medication and the side effects that may be experienced and the medication will only be prescribed if the potential benefits outweigh the potential harm. These judgements should be a collaboration between the patient and doctor, such that the patient's autonomy regarding decision making is optimised.

Justice

This principle refers to distributive justice, which is concerned with the fair distribution of resources between individuals. The British NHS was founded on the principle of equal access to treatment which is free at the point of need. The reality of limited resources leads to difficult decision making and establishing of priorities.

Mental Capacity Act

Mental capacity is the ability to make a decision. The Mental Capacity Act became law in 2005 and provides the legal framework for:

- people who lack capacity to make decisions for themselves
- people who have capacity and want to make provisions for when they might lose capacity in the future.

Principles of mental capacity

1. Mental capacity is decision and time specific, i.e. it is incorrect to say that an individual lacks mental capacity generally; rather, one should state that an individual does/not lack capacity to make a specific decision at a specific time.
2. An individual must always be presumed to have capacity unless proven otherwise.
3. An assessor, whilst making an assessment of mental capacity, must do everything possible to enhance an individual's capacity to make the decision in question.
4. Every adult has a right to make their own decisions (even unwise ones!) if they have mental capacity to do so.
5. In cases of individuals lacking capacity, those making decisions on their behalf must do so in their best interest.

Assessment of mental capacity

Assessment of capacity is a two-stage process and must be undertaken keeping the above principles in mind.

- *Stage I* Does the person have an impairment of mind or brain?
- *Stage II* If so, does the impairment mean that the person is unable to make the decision in question at the time it needs to be made?

To assess whether an individual is able to make the decision, one must assess their ability to understand, retain and weigh up information relevant to the decision and then communicate their decision by any means.

Lasting power of attorney (LPA)

An LPA gives the chosen person (attorney or donee) authority to make decisions that are as valid as ones made by the person (donor) themselves. An LPA can cover:

1. property and affairs decisions
2. welfare decisions.

Court of Protection

This is the special court set up to deal with decision making for adults who may lack capacity to make specific decisions for themselves.

Advance decision

An advance decision enables someone aged 18 or over, while still capable, to refuse specified medical treatment for a time in the future, when they may lack capacity to consent to or refuse that treatment.

Adults With Incapacity (Scotland) Act 2000

The Adults With Incapacity (Scotland) Act 2000 (AWI) is the equivalent legislation in Scotland to the Mental Capacity Act in England and Wales. The AWI has a number of principles with which the decisions regarding the adult should be made:

1. Beneficence
2. Minimum intervention
3. Consideration of the wishes of the adult
4. Consultation with relevant others
5. Encouraging the adult to exercise residual capacity

The assessment of capacity is the same as in England and a number of features are very similar. The AWI allows for the person to appoint a Power of Attorney which will continue if the person becomes incapable. There is also a Welfare Power of Attorney to make decisions regarding personal welfare.

An application is made to the Sheriff Court for an intervention order or a guardianship order. The intervention order is designed for one-off decisions; if there are ongoing concerns about the person's capacity then a guardianship order would be applied for. Both of the interventions require three reports: two from doctors and one from a social worker.

The AWI can authorise medical treatment, financial interventions and the adult taking part in research. The AWI does not allow for the use of force or detention in hospital. If the adult is being kept in hospital against their will then the Mental Health (Care and Treatment) (Scotland) Act 2003 should be considered.

Mental health legislation

Mental health legislation varies in different countries

The legislation for Scotland is detailed later but initially the Mental Health Act 1983 of England and Wales is considered. This legislation was amended in 2007. It applies to any patient with a mental disorder who needs to be detained in hospital but some sections (37, 47, 48, 49 and 41) are more common in the practice of forensic psychiatry due to their relation to the courts.

Mental Health Act 1983 of England and Wales

Criteria for detention

- In order to be detained under the Mental Health Act (MHA), a person must be determined to be suffering from a **mental disorder**. There is no definition in the legislation of 'mental disorder' other than that it is a disorder or disability of the mind. However, detention solely on the basis of dependence on alcohol or drugs is not permitted.
- It is also necessary to decide that the **nature** or **degree** of the mental disorder warrants detention in hospital (for assessment or treatment depending on the section used).
- It must be necessary for the **health** or **safety** of the patient or the **protection of others** that the patient be detained in hospital.
- For detention under section 3 or related treatment sections. **appropriate medical treatment** must be available. This is defined as '*medical treatment, the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations*'.

Professionals involved

The following professionals may be involved in the process of detention under the Mental Health Act, depending on the section under which the patient is detained.

- Section 12(2) approved doctor, who has been certified to have special expertise in mental health. Their role is to provide a medical recommendation for detention.
- In most cases a second medical recommendation is required and this must be independent of the first and ideally someone who has prior knowledge of the patient (patient's GP). If this is not possible, a second section 12(2) approved doctor's recommendation is usually used.
- Approved mental health practitioner (AMHP) is a role that was previously carried out by approved social workers but since the 2007 amendments to the MHA, can be taken on by other mental health professionals. AMHPs have received specific training relating to the application of the MHA. In relation to civil sections (section 2, 3, 4 and Community Treatment Orders), AHMPs make the application for detention to the hospital based on the medical recommendations and other relevant information.
- The responsible clinician (RC) is the approved clinician in charge of the patient's care. It replaces the previous term of responsible medical officer (RMO). At the time of writing, RCs are all psychiatrists but the 2007 amendments allow other mental health professionals to take up this role after special training.

Mental health review tribunals

- Patients may appeal their detention under the MHA by applying for a tribunal.
- The tribunal consists of an independent panel of a psychiatrist (usually a consultant), a lawyer and a lay person.
- They may decide to discharge the patient from hospital if they are satisfied that the criteria for detention are not met.

Section 5(2)

- Requires a recommendation by the RC or their nominated deputy who may be a doctor or an approved clinician (it is often the on-call psychiatric trainee).
- Maximum duration 72 hours during which a full MHA assessment should take place.

Section 2

- Requires two medical recommendations (as described above) and the recommendation of an AMHP.
- Maximum duration 28 days.
- Is for assessment of a mental disorder (and treatment if required).

Section 3

- Requires two medical recommendations and the recommendation of an AMHP.
- Initial duration is 6 months and can be extended by a further 6 months and then for periods of 1 year at a time.
- Is for treatment of a mental disorder.

Sections 47, 48 and 49

- These involve the transfer of patients from prison to hospital for assessment and treatment of mental disorders.
- Section 48 is used for remand prisoners (awaiting trial).
- Section 47 is used for sentenced prisoners.
- Section 49 is a restriction that is used in combination with section 47 or 48. It is imposed to protect the public from serious harm. Under this restriction, any leave of absence, transfer between hospitals or discharge must be sanctioned by the Ministry of Justice.

Sections 37 and 41

- Section 37 is a hospital order and is similar to a section 3. It is imposed by a court instead of a prison sentence on the basis of two medical recommendations.
- Section 41 is a restriction order that may also be imposed by the court in conjunction with a Section 37 if it is deemed necessary to protect the public from serious harm.
- Section 37/41 patients can only be discharged:
  - by a tribunal or
  - by the RC seeking the Ministry of Justice's approval.
- Once patients subject to section 37/41 are discharged, they will have to comply with conditions of their discharge, such as taking medication, or they will be recalled to hospital.

Community treatment orders

- Supervised community treatment was introduced in the 2007 amendments to the MHA.
- Community Treatment Orders may be used for patients who have been detained under section 3 or 37.
- They allow patients to live in the community whilst still being subject to the powers of the MHA for the purpose of receiving medical treatment and they can be recalled to hospital.

Other powers

- *Section 136* – police can detain people whom they believe to be mentally disordered in a public place to a place of safety for up to 72 hours.
- *Section 135* – magistrate can issue a warrant allowing entry to private premises to search for and remove patients thought to need urgent medical attention.
- *Section 5(4)* – nurses' holding power for inpatients that lasts for up to 6 hours.

Mental health legislation (continued)

- *Section 4* – emergency section of up to 72 hours requiring only one medical recommendation and application by an AHMP.
- *Section 17 leave* – leave from the hospital for patients detained under the MHA that must be approved by the RC.
- *Section 58* – this is concerned with consent to treatment and 3 months after medication is first administered, the patient must consent to it or the treatment plan must be agreed by a second opinion approved doctor (SOAD).
- *Section 117 aftercare* – patients who have been detained under section 3 or equivalent are entitled to free aftercare arrangements, including appropriate accommodation.

Mental Health (Care and Treatment) (Scotland) Act 2003

Criteria for detention

- The patient should have (or be suspected of having) a mental disorder. This is defined in the act as a mental illness, personality disorder or learning disability.
- Medical treatment would be likely to alleviate the symptoms or prevent worsening of the mental disorder.
- If the patient was not given the treatment, there would be a significant risk to the health, safety or welfare of the patient or to the safety of others.
- The patient has significantly impaired decision-making abilities about the treatment of their mental disorder.
- There is no other option but for the patient to receive this treatment (least restrictive option).

Exclusions for detention

A person cannot be defined as having a mental disorder for any of the following reasons:

- Sexual orientation
- Sexual deviancy
- Trans-sexualism/transvetism
- Dependence on or the using of drugs or alcohol
- Behaviour that causes alarm or distress to another person
- Acting as no prudent person would act

Professionals involved

- An approved medical practitioner (AMP) is a psychiatrist approved under section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 as having special experience and expertise in the diagnosis and treatment of mental disorders. This is usually a ST4 or above.
- A responsible medical officer (RMO) is the consultant psychiatrist in charge of the patient's care.
- Mental health officers (MHOs) are social workers trained in dealing with people with mental health problems. The MHO is consulted to assess if the patient requires detention under the Mental Health Act.
- The patient has a 'named person' whom the clinical team must consult about the treatment and detention of the patient. This is usually a relative but can be anybody nominated by the patient.
- Mental health tribunals are the same as in England and Wales.

Emergency detention certificate (EDC/Section 36)

- Any doctor with General Medical Council full registration can complete this but the person should be reviewed as soon as possible by an AMP.

- Can last for 72 hours.
- Only allows for detention in hospital and assessment, NOT treatment.
- Should be with MHO consent but in emergencies can be completed without.
- There is no right of appeal against this section.

Short-term detention certficate (STDC/Section 44)

- Is implemented by an AMP and MHO.
- Lasts for 28 days.
- Allows for treatment as well as assessment.
- Can be appealed against with application to the mental health tribunal.
- Has to be declared for travel purposes (e.g. visas to visit the USA).
- Should be used in preference to the EDC for the detention of patients.

Compulsory treatment orders (CTOs/Section 63)

- This section is granted by the mental health tribunal.
- There are two recommendations made to the tribunal, by the RMO and another doctor, usually an AMP. The MHO is also consulted and should be in agreement.
- Is initially for a period of 6 months; this can be extended for 6 months and then renewed annually if required.
- It can be appealed against to the mental health tribunal.
- CTOs can be hospital based or community based, which allows for compulsory treatment in the community.

Other powers

- As with the English Mental Health Act, there are other powers available to the police and nursing staff holding powers.
- Patients can be moved from the courts and prisons for assessment/treatment of their mental health.
- These transfers are completed under the Criminal Procedures (Scotland) Act 1995 as amended by the Mental Health (Care and Treatment) (Scotland) Act 2003.
- The sections used depend on where in the legal process the patients are; for more information, see the Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice, all three volumes of which are available on the Scottish government website.
- The Mental Health Act forms are also available online.