The Royal College of Emergency Medicine

50 Years of Emergency Medicine

Mental Health in Emergency Departments

A toolkit for improving care

Revised: October 2017

The Core Principle of Mental Health in the Emergency Department:

A patient presenting to ED with either a physical or mental health need should have access to ED staff that understand and can address their condition, and access to appropriate specialist services, regardless of their postcode, GP or time of arrival.

Introduction

Most of us who treat patients with mental health problems coming to the ED in crisis will be aware that timely and quality treatment often remains difficult to deliver. There has been a welcome national focus on crisis care with the Mental Health Crisis Care Concordat and investment is starting to follow, however there is a long way to go.

Attendances by patients in mental health crisis continues to rise by around 10% per year [1]. A RCEM survey in 2016 showed that 31% of respondents felt that crisis care overall had improved whilst 26% felt it had got worse. 49% of respondents felt care had deteriorated for children and young people.

We owe it to our patients to work to improve care both by our ED staff and to push for better mental health care services in and out of hours. Current systems especially out of hours lead to significant delays in receiving definitive care, as well as time spent in a non-therapeutic and potentially harmful environment. There is also the knock-on effect of operational pressures and crowding within the ED.

We hope that this tool kit will equip and inspire Emergency Departments and Liaison services to fight for better services as well as improve the quality of our own ED care.

Kate Swires-Hennessy **Catherine Hayhurst**

With input from the Mental Health Sub - Committee and the Quality in Emergency Care Committee.

With thanks and acknowledgement to Anne Hicks, previous RCEM Mental Health lead and author of the original toolkit.

[1] NHS Digital, Hospital Accident and Emergency Activity, 2015-16, http://www.content.digital.nhs.uk/catalogue/PUB23070

Contents

Section 1 – Improving the Quality of ED Services

Initial Assessment (Triage)

Any patient presenting with mental illness should undergo a risk assessment at triage. This will help to identify the appropriate space for the patient to be nursed, their risk of absconding and whether special observations or a security presence may be necessary.

In addition, the initial assessment is a suitable time for information to be delivered as well as gathered by nursing/triage staff.

Feeling on the Edge is a leaflet currently produced by the Royal College of Psychiatrists (RCPsych), with approval of multiple colleges, including our own, to give to self-harm patients at triage. It explains the process and gives information about services. This leaflet is likely to reduce the proportion of "did not wait" patients, and is highly rated by staff and patients.

The initial assessment provides an opportunity to advise the patient of alternatives to the ED, if it becomes apparent that there is no acute physical need. Many places have third sector services (e.g. Safe Haven Café,) for patients in mental health crisis. In some cases, the triage process will identify patients without physical illness who may be appropriate for a "fast track" referral directly to psychiatry services, without the need to be seen by an ED clinician.

Links

- Australian Mental Health Triage
- Example of adult risk assessment
- Example of child risk assessment
- Example of a CAMHS risk assessment triage tool
- Example of a 1:1 policy
- First response leaflet
- First response incorporated into ED triage)
- Safe Haven Café flyer
- Feeling on the Edge leaflet

Proforma

Trying to meet national standards of documentation is a real challenge without a proforma. Mental health clerking detail is commonly poor in ED notes, and without a prompt it is unlikely that doctors will record the key findings that inform risk.

The NCEPOD report *Treat as One* has specified certain elements of a clerking which should be included in an emergency assessment of any mental health patient. They have also suggested that details of any patient's mental health should be recorded, even if the patient is not presenting with a mental health related issue.

Various departments may already have their own mental health proforma, but in light of NCEPOD's recommendations, it may be necessary to adapt a mainstream clerking proforma to include mental health details as well as to have a specific mental health cascard. Some examples are collated here for your consideration (see right).

Links

- Example of a MH cascard
- Example – 4 areas approach to assessing AED patients following self-harm
- Deliberate self-harm proforma

Junior Induction

Mental health is a high risk area of our practice, and as such should feature specifically within junior doctor induction. This is particularly important because the provision and style of mental health services varies so dramatically across the country/county/city. Where feasible, it may be a good idea to include some of the psychiatry liaison staff in your induction as putting faces to names makes for better communication and better patient care. Induction should include referral pathways, use of 1:1 policy, section 136 processes, and reiterate the standard expected for a ED assessment.

Staff Education

It is instructive to ask if the education, training and clinical knowledge of your staff in mental health matches that for major trauma, cardiac arrest, paediatric safeguarding etc? Nursing staff should have access to regular training in mental health so that they are able to assess risk and contribute in a positive way to the patient's condition. It is a key element of liaison teams that they should also engage in education of ED staff (see PLAN standards).

Including mental health topics within junior doctor teaching programmes (eg the management of disturbed behaviour, the MHA and MCA, and other clinically relevant, curriculum-based topics) is also beneficial.

Curriculum links for EM juniors:

- CAP4 Aggressive/disturbed behaviour
- CAP8 Confusion, acute/delirium
- CAP30 Mental Health
- HAP3 Alcohol and substance misuse

Links

- PLAN standards Domain 5, p 43
- Example of a teaching session (powerpoint slides)
- Example of a MH study day programme/template

Section 2 – Suitable environment

There is no question that the middle of an ED, whether busy or quiet, can be a very stressful environment for any patient. However, if a person is feeling paranoid, psychotic, distraught or suicidal, the environment can be clearly detrimental, and potentially escalate symptoms. Any assessment area needs to be safe for staff, and conducive to valid mental health assessment. Standards for these areas are described in PLAN.

Importantly, the assessment room must be safe for both the patient and staff. Therefore, there should be no ligature points, and nothing that can be used as a weapon. The room should have an alarm system and two doors (that open both ways). It is not acceptable to use a room that doubles as an office. This is the requirement that most often prevents a liaison service from achieving full PLAN accreditation, even though it is a core element of providing a therapeutic and safe environment to this patient group.

Links

- PLAN guidance Domain 2 p 38

Section 3 – Liaison Psychiatry Service

There is plenty of evidence that a liaison service is of huge benefit to patients, staff and the acute trust. Often services developed just for an ED are too small, and the staff risk becoming burnt out, or the service unsustainable. If the service is commissioned for the whole acute trust, then all patients benefit, staff are more resilient, and the response to mental health within the trust becomes timely and consistent.

Any service based outside an acute trust usually struggles to provide a timely response, and tends to have responsibilities elsewhere. Liaison psychiatrists are specifically trained to deal with patients in this field, and will add more to the patients and hospital Trust than a general trained psychiatrist. It is not appropriate to cover an acute trust service without a liaison consultant psychiatrist to lead the service. As well as assessing patients presenting acutely with mental health illness, the service should be able to provide advice and support to patients with concurrent physical and mental health problems and patients with medically unexplained symptoms (MUS) where appropriate.

The composition of a liaison team has most recently been detailed in the *Achieving Better Access* guides, based on the original recommendations by the Centre for Mental Health. The current advice in England is that hospitals that have 24/7 acute services should have 24/7 liaison psychiatry either core or comprehensive model.

Ideally the service should provide an ageless response, i.e. it has the capacity to deal with patients of all ages.

When dealing with older adults, the mental health clinicians are more likely to follow patients through onto the wards and therefore work with Medicine for the Elderly and the whole multidisciplinary team. There is great potential to improve lengths of stay by working with these patients jointly.

Links

- NHS England Achieving Better Access to 24/7 urgent and emergency care – Liaison Psychiatry guide
- NHS England Achieving Better access to 24/7 Urgent and Emergency Mental Health Care – Liaison Psychiatry appendices and helpful resources
- Centre for Mental Health - This has older examples of service models.
- Commissioning guide for acute hospitals for services for patients with Medically Unexplained Symptoms
- Psychiatric Liaison Accreditation Network (PLAN) guidance
- NCEPOD report Mental Health in Acute Hospitals: Treat as One

Section 4 - Services for Children and Young People

Mental health provision for children and young people remains the most under-resourced of all mental health services, whilst attendances in children and young people continue to rise. This area should almost certainly be on the risk register in most trusts. For some the risks are around the inability of services to assess in a timely manner, for many the long waits to find a CAMHS bed impact on the care of patients and pressure on the organisation as a whole.

A useful service model is where the liaison psychiatry team are trained to work with older teenagers and have good support from CAMHS teams.

The practice of admitting all young people for an assessment the next day is not evidence based and in some cases can be unhelpful for the patient. RCEM recommends that a risk assessment should be completed by a mental health clinician with some CAMHS training to determine whether the patient is high risk and needs to stay in or whether they can go home and be seen the next day by CAMHS for a full assessment.

Section 5 – Multidisciplinary services

Mental health patients in the acute trust have a high rate of co-morbidities with alcohol, substance misuse or other vulnerabilities. Close links with safeguarding also promote good holistic care.

Therefore, to provide a patient-centred service there needs to be a multidisciplinary team that can deliver joint assessments in a timely fashion. This also provides an environment within the team that offers peer support and supervision. All practitioners working in this field are, by definition, working with a high risk population, and so the provision of a large team with which to share practice/concerns and learning promotes a sustainable working environment.

In the case of comorbid alcohol or substance misuse, referral for assessment by an Alcohol Specialist Nurse is also likely to be necessary and beneficial. The RCEM Alcohol Toolkit provides further information and guidance about this area.

Links

- Example – adult liaison team poster
- Salford alcohol assertive outreach service
- RCEM alcohol tool kit 2015

Section 6 – Governance - Collate risk, incident forms, 4 hour & 12 hour breaches, complaints

Identifying and recording risks associated with mental health care within your organisation can be a real driver for resource and change. Frequently mental health services are structured around geographical boundaries: the acute trust should be the focus for all of these reports, otherwise the true picture is lost.

Many of the longest waiting ED patients are mental health. Due to the nature of the admission process, often the fact that they remain in ED for over 24 hours can be lost and they do not appear within the 12 hour bed request breach figures. A method for ensuring they are counted should be made possible in each organisation to allow correct data interpretation.

A good model is to have a joint governance meeting with your mental health provider with input from liaison and other services within the trust – inpatient, crisis team, duty medical team etc. Incidents, SIs, complaints, risks and breaches can be reviewed regularly.

In addition, give thought to including mental health cases in your ED Mortality & Morbidity governance structure. This will allow a forum to discuss significant cases and learn from current practice.

Investigation of serious incidents should have oversight from both acute hospital and mental health trusts as incidents often involve both organisations. If a patient or relative receives two separate responses to a complaint or incident this underlines the gaps in service provision, whereas a joint response is more likely to promote better working. If joint governance is impossible within a trust, then an alternative process should be arranged whereby cases can be reviewed by both the acute trust and the mental health trust.

Links

- Example of risk analysis
- Generic agenda for a MH Governance meeting
- RCEM Safer Care Toolkit

Section 7 – Commissioning blocks

There are several unintentional, but significant, blocks to liaison service commissioning:

1. If an acute trust doesn't already have a liaison service, there will be no one campaigning for it. General psychiatrists will not necessarily be advocates for the development of a service that will compete financially with theirs, and most people in the acute trust don't see it as their job. Commissioners will not be looking for services on which to spend money.

2. A well-run liaison service will save bed days for both the acute trust and mental health. The RAID model showed this predominantly by reducing length of stay for elderly patients. It may also be shown that better services for mental health patients also reduce breaches in ED, Clinical Decision Unit bed occupancy and reduce nursing time for 1:1 observation. However, it can be a challenge to demonstrate a strong business case for a 24 hour ED service on its own, showing that it will pay for itself by the amount saved. It is preferable to develop the liaison service as a whole. There needs to be acceptance at commissioner level that there is benefit across the health community from a properly established and sustainable liaison service. It may be that an attendance to the acute trust, either as a result of a mental health crisis or as an incidental finding, may give a unique opportunity for assessment, intervention and engagement that results in real therapeutic gains.

3. Not infrequently, the geographical footprint of mental health services differs to the acute trust footprint, which leads to different service provision for patients from different areas attending the same acute hospital. This can promote inequality of access to services, and frequently contributes to significant delays in patient assessment and disposition.

Links

- Developing models for Liaison Psychiatry Services – Guidance from strategic clinical network for Mental Health, Dementia and Neurological conditions South West. 2014.
- Guidance for Commissioners of Liaison Psychiatry services to Acute Hospitals

Section 8 – Strategic presence in the acute trust

There will never be a time when liaison psychiatry is a priority for funding within a Community Mental Health Trust (CMHT). Therefore, the acute trust must push consistently for an appropriate and effective liaison service. There needs to be a liaison strategic hub within the acute trust for the following reasons:

a) Trust risk register: identify the risk to patients with unmet liaison needs

b) Compliance with national guidelines (this should be evidenced)

c) Most benefits are trust-wide, or realised across the wider healthcare community, for example with patients with medically unexplained symptoms.

d) Identification of acute trust service provision needs and gaps in service.

e) Enables disparate commissioning groups to agree joint working /shared resourcing

f) Transparent communication links with community services

g) The bigger issues raised from mental health governance processes looking at incidents and complaints should be escalated to the acute trust executive body.

Links

- Example of MH risk register

Section 9 – Frequent Attenders and Care Plan Management

There are several patient groups with a mixture of mental health, substance misuse and chronic medical problems that benefit from a consistent response. To help frequent attenders to the ED, the development of an agreed care plan may alter behaviours and contribute more constructively to the patient's needs. For example, some patients who are well known to services may benefit from a low key response from the ED, without formal review by liaison staff, but a timely alert to their community team. In other cases, strategies to avoid admission or over-investigation may benefit the patient.

These care plans need to be actively managed and archived. They should be composed using all appropriate clinicians from the acute trust, mental health, primary care and community services, which may include the police and ambulance service. They should include input from the patient as much as possible.

This is an important element of a liaison service in England, since the introduction of the mental health CQUIN in 2017 which requires EDs to reduce the number of attendances for a chosen group of mental health patients by 20% within the year.

ED staff and liaison staff should attend High Intensity User group meetings held by ambulance services and police, in order to work collaboratively.

It is useful for individual EDs to nominate a named consultant to co-ordinate and manage these plans.

Links

- RCEM Frequent Attenders Guideline
- RCEM Frequent Attenders position statement

Section 10 – Evaluation and Service User Involvement

ED and mental health services can be monitored and evaluated through various means. It is recommended that key performance indicators, such as time from arrival to referral to psychiatry, time from referral to assessment and percentage of patients admitted, are monitored.

Throughout mental health, service users have informed the development and delivery of services. This has been useful for both commissioners and providers, and it is highly recommended that service users provide input to commissioning and healthcare staff. This can be in the form of an occasional focus group, structured interviews or asking for written feedback. Allowing a service user to talk directly to staff about their experience of being in the ED can be a very powerful tool for change in attitudes and care giving.

Links

- Example of KPI for Liaison Service

Section 11 – Strong links with ED, Liaison and Community Mental Health Teams

There should be regular meetings between the acute trust/ED and your main provider of liaison psychiatry, so that you can increase links and understand each other. Involvement in each other's induction programme really helps to improve response times and flow of service. For the pure psychiatry trainees or staff grades, they may have no knowledge of the ED's clinical standards or time requirements. Equally, we need to understand the competing pressures that exist in mental health.

Forming links between the ED and other services can also be helpful such as the crisis team, 136 suite, personality disorder services, CAMHS and services for the homeless.

Transfer policy

Inevitably there is a regular flow of patients to and from the acute trust and mental health inpatient unit. It is helpful to meet and produce a shared policy to guide this process to ensure that clear lines of communication and responsibility are established. This includes some basic logistics, but should focus on the sharing of appropriate information and handover of care. Whilst some of this centres around MHA legislative requirements, there are also guidelines to ensure good transfer of clinical data.

Links

- Example Transfer Policy

Section 12 – Mental Health Act Policy Including Section 136.

All areas in England will have a multi-agency policy for S136 patients. There should be an appendix relating to the use of Emergency Departments. It is prudent to ensure that this is appropriate for your local service, and that the ED is only used for S136 patients who have an acute healthcare need. Otherwise, it should be expected that mental health services should provide an assessment suite, or alternative space within the mental health unit, where a S136 patient can be assessed. RCEM agrees that police custody is not a suitable alternative when a S136 suite is unavailable.

The policy should also include a strategy to ensure that acceptable time frames for a mental health act (MHA) assessment are established, with provision for police to remain with the patient if they are managed in the ED.

Links

- S136 update from the Policing and Crime Act 2017
- London's Section 136 pathway
- Example S136 Flowchart
- RCEM Guideline – The Mental Capacity Act in Emergency Medicine – deals with MHA and MCA

Section 13 – National Representation and Resources

- NICE. The college has members sitting on the guideline development groups and expert reference groups where the outputs are relevant to the ED, eg self-harm, delirium and alcohol.
- PLAN (Psychiatric Liaison Accreditation Network). The accreditation committee for this is only quorate with representation from RCEM.
- Close working relationship with the Faculty of Liaison Psychiatry are in place to ensure collaborative working in all areas, but particularly on preventing suicide and the management of self-harm. CEM is also involved in the current rewrite of CR118: Psychiatry in Accident and Emergency Departments.
- Preventing Suicide in England - National Suicide Prevention Strategy 2012. The College was consulted on several areas of this document.

Links

- NICE
- PLAN
- Faculty of Liaison Psychiatry

Section 14 – Useful documents and web resources

- Achieving better access to Mental Health Services by 2020
- Kings Fund – Mental Health and New Models of Care: Lessons from the Vanguards P 30.
- The 5 year forward View for Mental Health – chapter 2
- Crisis Care concordat
- MHA Code of Practice
- NCEPOD Treat as One full document
- Rapid Tranquilisation Policy
- CLEAR Campaign poster

Section 15 – Accreditation

The RCPsych runs PLAN (Psychiatric Liaison Accreditation Network). Liaison services pay to sign up to gain accreditation. The cycle involves the submission of a self-audit, a visit by a peer review team who conduct an external review, and then all the information is considered at an accreditation panel. The process is wide in its remit, and may consider all sizes of service. It looks at the personnel within the service and also the environment, education of ED staff, patient and carer feedback, etc.

Where a service is accredited by PLAN, this offers assurance and benchmarking, which can provide a defence against future resource constraints. However, if the service does not meet the standard for accreditation the feedback is thorough, and where necessary involves communication at board level to demonstrate deficiencies in services and routes for improvement. This can be a significant driver for resource allocation and change.

The PLAN standards are regularly reviewed, and the accreditation panel consists of representatives from the RCPsych, RCP, RCEM, RCN, MIND and service users.

Links

- Psychiatric Liaison Accreditation Network (PLAN)

Section 16 – RCEM standards for mental health

1. Patients who have self-harmed should have a risk assessment in the ED
2. Previous mental health issues should be documented in the patient's clinical record
3. A Mental State Examination (MSE) should be recorded in the patient's clinical record
4. The provisional diagnosis should be documented in the patient's clinical record
5. Details of any referral or follow-up arrangements should be documented in the patient's clinical record
6. From the time of referral, a member of the mental health team will see the patient within 1 hour
7. An appropriate facility is available for the assessment of mental health patients within the ED

Links

- 4 areas approach for assessing AED patients following self-harm

Authors

Kate Swires-Hennessy and Catherine Hayhurst

First published in February 2013, revised October 2017

Acknowledgements

Anne Hicks, Mental Health Committee, QEC committee

Review

Usually within three years or sooner if important information becomes available.

Conflicts of Interest

None

Disclaimers

RCEM recognises that patients, their situations, Emergency Departments and staff all vary. This guideline cannot cover all possible scenarios. The ultimate responsibility for the interpretation and application of this guideline, the use of current information and a patient's overall care and wellbeing resides with the treating clinician.

Research Recommendations

None

Audit standards

None

Key words for search

Mental health, section 136

The Royal College of Emergency Medicine

The Royal College of Emergency Medicine
7-9 Breams Buildings
London
EC4A 1DT
Tel: +44 (0)20 7400 1999
Fax: +44 (0)20 7067 1267
www.rcem.ac.uk
Incorporated by Royal Charter, 2008
Registered Charity number 1122689