



The Royal College of
Emergency Medicine

Mental Health in Emergency Departments

**A toolkit for
improving care**

**Revised:
October 2019**

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.

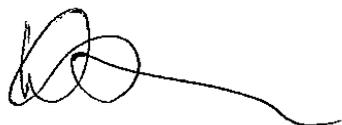
Introduction

Most of us who treat patients with mental health problems coming to the Emergency Department in crisis will be aware that timely and quality treatment remain difficult to deliver. There has been a welcomed national focus on crisis care with the Mental Health Crisis Care Concordat, and investment is starting to follow with the commitment to provide core 24 Liaison Psychiatry services in 70% acute hospitals in England and Wales by 2023/4.

Attendance from patients in mental health crisis continue to rise. National hospital episode statistics 2017-18 data showed an increase in mental health attendances by 133% between 2009/10 and 2017/18.¹

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.

We hope that this toolkit 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 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, 2017-18, <https://digital.nhs.uk/data-and-information/publications/statistical/hospital-accident--emergency-activity/2017-18>

Contents

Introduction	2
Section 1 – Improving the Quality of ED Services	4
RCEM mental health audit standards for Individual patients	4
RCEM mental health audit standards for the Emergency Department	5
Mental Health Triage	6
Proforma	7
Junior Induction	7
Staff Education	8
Section 2 – Suitable environment	9
Assessment area	9
Observation area	9
Section 3 – Liaison Psychiatry Service	10
Section 4 - Services for Children and Young People	11
Section 5 - Restrictive intervention and Rapid Tranquilisation	12
Section 6 – Multidisciplinary services	13
Section 7 – Governance – Risk registers, incident forms, 4 hour & 12 hour breaches, complaints.	14
Section 8 – Commissioning blocks	15
Section 9 – Strategic presence in the acute trust	16
Section 10 – Frequent Attenders and Care Plan Management	17
Section 11 – Evaluation and Service User Involvement	18
Section 12 – Strong links with ED, Liaison and Community Mental Health Teams	19
Transfer policy	19
Section 13 – Mental Health Act Policy Including Section 136.	20
Section 14 – National Representation and Resources	21
Section 15 – Useful documents and web resources	22
Section 16 – Accreditation	23
Authors	24
Acknowledgements	24
Review	24
Conflicts of Interest	24
Disclaimers	24
Research Recommendations	24
Key words for search	24

Section 1 – Improving the Quality of ED Services

RCEM mental health audit standards for Individual patients

1. Patients should have mental health triage by ED nurses on arrival to briefly gauge their risk of self-harm, suicide, and risk of leaving the dept before assessment or treatment is complete. This is used to determine what level of observation the patient requires whilst in the ED.
2. Patients at medium or high risk of self-harm or suicide should be searched for objects or medication that may be used to self-harm.
3. Patients at medium or high risk of suicide or of leaving before assessment and treatment are complete should be observed closely whilst in the ED. There should be documented evidence of either continuous observation or intermittent checks (recommended every 15 minutes), whichever is most appropriate.
4. If a patient states that they want to leave or decline treatment, then there should be documentation of the assessment of that patient's capacity to make that particular decision at that time, based on a face-to-face conversation and not rely on records from previous attendances.
5. When an ED doctor reviews a patient presenting with self-harm or a primary mental health problem, they should conduct a brief risk assessment of suicide and further self-harm.
6. Previous psychiatric history should be documented in the patient's ED clinical record. This should include previous self-harm or suicide attempts, previous admissions and current treatment.
7. A Mental State Examination (MSE) should be recorded in the patient's ED clinical record.
8. From the time of referral, a member of the mental health team should see the patient face-to-face and offer appropriate assistance to both patient and referrer within one hour. Full assessment may be delayed if the patient is not yet fit for assessment.
9. People who have attended the ED for help with self-harm should receive a comprehensive biopsychosocial assessment with appropriate safety or care planning at every attendance, unless a joint ED/Psychiatric written management plan states that this is not necessary or unhelpful.
10. Details of any referral or follow-up arrangements should be documented in the patient's ED notes.

RCEM mental health audit standards for the Emergency Department

1. Each department should have a named Mental Health Lead.
2. A policy and process for assessing and observing patients should be in place for those considered to be high risk of self-harm, suicide, or leaving before assessment and treatment are complete.
3. EDs should have a policy and process which clearly states when patients can or cannot be searched. This should be compliant with relevant legislation and have clear processes to safeguard or chaperone patients who are searched and to record the procedure. Searches which are for the clinical safety of the patient should be conducted by clinical staff rather than security guards.
4. An appropriate area of the ED should be available in which patients with mental health problems may be observed. This should be both safe and as calm and quiet as possible.
5. ED and mental health teams should have joint pathways which promote parallel assessment of patients with both physical and mental health needs. Mental health assistance should be delivered at the time that it is requested in line with the recommendations in the NCEPOD *Treat as One* report; terms such as “medically fit” or “medical clearance” should not be used to delay this.
6. Departments should follow their trust's policy for restrictive intervention and should follow guidance for Rapid Tranquilisation (NICE or their own guideline).
7. EDs should have a policy and process for patients under the relevant policing and mental health legislation - including section 297 (Scotland), section 130 (Northern Ireland) or section 136 (England and Wales) to ensure safety, dignity, and timely management.
8. An appropriate room should be available for the assessment and assistance of people with mental health needs within the ED. These should meet the standards of the Psychiatric Liaison Accreditation Network (PLAN).
9. An appropriate programme should be in place for to train ED nurses, health care assistants, and doctors in mental health and mental capacity issues.

Mental Health Triage

Any patient presenting with mental illness should undergo mental health triage upon arrival. The purpose of this is to gauge the ongoing risk of self-harm or suicide, and the risk of the patient leaving the ED before assessment and treatment. This will determine where the patient should be placed in the ED and what level of observation they require to keep them safe. It should also promote referral to mental health services from triage to enable joint working. Patients at risk of self-harm should be searched (with consent) to check for objects or medications that may be used for further self-harm. Searches which are for the clinical safety of the patient should be conducted by clinical staff rather than security guards. 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 and the patient is safe to access these services. Examples of this are telephone mental health services and crisis cafes.

Links

- [Example of adult mental health triage](#)
- Example of VISA Assessment [form](#), [guide](#), and [observation record](#)
- [APEX Acute Psychiatric Emergencies course \(ALSG\) AEIO system](#)
 - **A** How agitated is the patient?
 - **E** Is the environment safe?
 - **I** What is the patient's current intent – for self-harm or absconding?
 - **O** Does the patient have any objects on them that they may harm themselves with?

- Example of [property search policy](#)
- [RCEM absconding patient guideline](#)
- [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 the 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.

- [Example of a MH cascard](#)
- [Example of Mental Health Risk Pathway](#)
- [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 vary so dramatically across countries, counties, and cities. 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 an ED assessment.

Staff Education

It is useful to ask if the education, training and clinical knowledge of your staff in mental health matches that for major trauma, cardiac arrest, paediatric, and safeguarding standards.

Nursing staff, including health care assistants, should also 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 (e.g. 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](#)
- [Acute Psychiatric Emergencies course \(APEX\) ALSG](#)

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 can potentially escalate symptoms.

Assessment area

Any assessment area needs to be safe for staff, and conducive to a valid mental health assessment. Standards for these areas are described in PLAN. 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.

Observation area

A patient may be observed in a different space to where they undergo assessment by the mental health team. Departments should consider how they can make these spaces as safe, quiet, and calm as possible. A brief risk assessment of the environment should be made whenever a patient is at risk of self-harm is put in a cubicle.

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. Services developed just for an ED are often too small, unsustainable, and staff risk becoming burnt out.. 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 can benefit the patients and hospital Trust more 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 a 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](#)
- [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 add 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.

Links

- [Example of child mental health triage](#)
- [Example of a CAMHS risk assessment matrix](#)
- [Referral from triage pathway Manchester](#)

Section 5 - Restrictive intervention and Rapid Tranquilisation

Patients with mental health problems who are actively trying to leave may need to be kept in the ED, initially by staff listening and talking to them to try to persuade them to stay. An assessment of the patient's capacity to decide to leave should be made by a senior decision maker.

If a patient is assessed as lacking capacity or is already being kept in the ED under another legal framework, e.g. the Mental Health Act, and persuasion or de-escalation has failed, then the patient may need to be restrained. Restraint should be proportionate to the risk presented by the patient and should be carried out by staff who are trained.

If a patient is needing to be restrained for more than 10 minutes, and de-escalation has failed, NICE guidance states that Rapid Tranquilisation should be given.

Hospital trusts should have a policy on restrictive and physical intervention. All episodes of physical intervention (restraint) should be monitored by the trust's security lead. Inappropriate uses of restraint and / or rapid tranquilisation should be investigated and outcomes shared.

Links

- [RCEM absconding guideline](#)
- [RCEM MCA guideline](#)
- [RCEM acute behavioural disturbance guideline](#)
- [NICE guideline on short term management of violence and aggression](#)
- [Example of ED Rapid Tranquilisation guideline](#)

Section 6 – Multidisciplinary services

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

Therefore, to provide a patient-centred service there must 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 toolkit 2015](#)

Section 7 – Governance – Risk registers, incident forms, 4-hour & 12-hour breaches, and complaints

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

Many of the longest waiting ED patients have mental health problems. 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.

ECIST have developed an audit of Mental Health patients which can help get evidence for gaps in service and help with 4 and 12 hour breach analysis. ECIST can also help with analysis of results.

Links

- [Example of risk analysis](#)
- [Generic agenda for a MH Governance meeting](#)
- [RCEM Safer Care Toolkit](#)
- [ECIST audit tool](#)

Section 8 – 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 for funding 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 9 – 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, e.g. patients with medically unexplained symptoms
- d) Identification of acute trust service provision needs and gaps in service
- e) Enable disparate commissioning groups to agree to joint working or 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 10 – 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 in 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 police and ambulance services. 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](#)
- [Bristol High Intensity Users toolkit](#)
- [Oxford frequent attender program](#)

Section 11 – 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 12 – 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 is centred around MHA legislative requirements, there are also guidelines to ensure good transfer of clinical data.

Links

- [Example Transfer Policy](#)

Section 13 – Mental Health Act Policy & Section 136 patients

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 appropriately 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.

Where police bring patients to the ED, not using a mental health legislative framework, there should be systems in place for good handover.

Links

- [RCEM Section 136 guideline](#)
- [S136 update from the Policing and Crime Act 2017](#)
- [London's Section 136 pathway - Peer review of mental health crisis pathways for children & young people](#)
- [Mental health crisis care for Londoners: Section 136 pathway and health based place of safety specification](#)
- [London police handover process \(not 136\)](#)
- [Example S136 Flowchart](#)
- [RCEM Guideline – The Mental Capacity Act in Emergency Medicine – deals with MHA and MCA](#)

Section 14 – National Representation and Resources

- NICE - The College has had members sitting on the guideline development groups and expert reference groups where the outputs are relevant to the ED, e.g. self-harm, delirium, and alcohol.
- PLAN - 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.

Links

- [NICE](#)
- [PLAN](#)
- [Faculty of Liaison Psychiatry](#)

Section 15 – Useful documents and web resources

- [ALSG – APEX course Acute Psychiatric Emergencies](#)
- [Achieving better access to Mental Health Services by 2020](#)
- [Kings Fund – Mental Health and New Models of Care: Lessons from the Vanguard P 30.](#)
- [The 5 Year Forward View for Mental Health](#)
- [Crisis Care Concordat](#)
- [MHA Code of Practice](#)
- [NCEPOD Treat as One full document](#)
- [HSIB Mental Health Investigation](#)
- [RCEM CLEAR Campaign poster](#)
- [MARSIPAN guidelines for Anorexia Nervosa](#)
- [Royal College of Psychiatrists](#)

Section 16 – Accreditation

The RCPsych runs PLAN 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, the environment, the education of ED staff, and feedback from patients and carers.

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 \(PLAN\)](#)

Authors

Kate Swires-Hennessy and Catherine Hayhurst

This version was published in October 2019.

First published in February 2013, revised October 2017 and March 2019

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

Suicide risk assessment in the ED

Benefits of joint working between ED and Liaison Psychiatry

Reducing restraint in the ED

Key words for search

Mental health, mental health triage, suicide risk assessment, liaison psychiatry, 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